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ABSTRACT

This guide was developed to provide effective and practical strategies to meet the needs of prenatally substance-exposed children in preschool or day care settings. Techniques are based on good child development practices and are equally effective for both teachers and parents. The first chapter outlines information about prenatal substance exposure, such as the effects of different drugs on the fetus and the resulting behaviors and learning characteristics. The second chapter presents teaching strategies, including protective factors involving daily routines, transitions, and rules; facilitative factors such as relationships, peer sensitivity, and decision making; and strategies for play, communication development, motor development, social/emotional development, and home-school partnerships. Characteristics of an exemplary child development program are then described in chapter 3. Practical guidelines are offered for dealing with parents with chemical dependency in chapter 4. The final chapter focuses on assessment and offers a preschool assessment protocol consisting of a parent interview and developmental history, administration of developmental screening tests and instruments, play observation, and behavioral observations. An appendix lists organizational resources, training resources, written resources, videotapes, audiotapes, free reference materials, newsletters, and other resources; another appendix defines terms. (Each chapter contains references.) (JDD)

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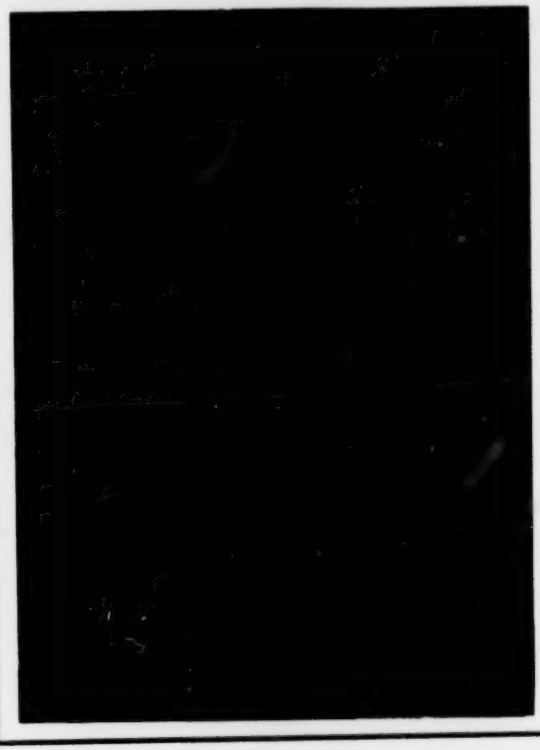

A practical guide for working with children prenatally substance-exposed

California Department of Education
Sacramento, 1994

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for working with children
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CONTENTS

Preface vi

Acknowledgments vii

Chapter 1: Prenatal Substance Exposure: Information and Facts 1
- Introduction 1
- A Look at the Problem 1
- How Many Children Are Affected? 1
- What Are the Effects of Prenatal Substance Exposure? 1
- What Do the Children Look Like? 1
- Behaviors and Learning Characteristics 2
- When Tammy Comes to School 3
- Strategies for Working with Tammy 3
- Selected References 4
- How Do Different Drugs Affect the Fetus? 5
- Myths and Facts About Substance-Exposed Children 6
- The Child at Risk: Checklist of Characteristics 7

Chapter 2: Helpful Teaching Strategies That Work with Children at Risk Due to Prenatal Substance Exposure 9
- Introduction 9
- Protective Factors 9
  - Daily Routines 9
  - Staff 10
  - Transitions 10
  - Learning Environment 11
  - Change 12
  - Rules 12
  - Group Size 12
  - Play 12
  - Curriculum 12
  - Observation 13
- Facilitative Factors 13
  - Respect 13
  - Relationships 13
  - Feelings 13
  - Mutual Discussion 14
  - Role Model 14
  - Peer Sensitivity 14
  - Decision Making 14
  - Home-School Partnership 14
  - Transdisciplinary Model 14
- Teaching Strategies 15
  - Learning 15
  - Play 17
  - Social/Emotional 19
  - Communication 22
  - Motor 24
  - Home-School Partnership 25

Chapter 2: (continued)
Selected References 27
Educational Needs of Children at Risk 28
Strategies for Healthy Development of Children at Risk 29
Checklist of Behavioral Indicators for Children with Overwhelming Stress 30

Chapter 3: Characteristics of an Exemplary Child Development Program Providing Education and Care to Children at Risk Due to Prenatal Substance Exposure 31
Introduction 31
What an Exemplary Program Looks Like 31
Interactions Between Staff and Children 31
Child Care and Preschool Staff Interactions 31
Parent and Staff Interactions 32
Child Interactions 32
The Learning Environment 32
Taking Care of Yourself 33
Selected References 33
Checklist for Indicators of Quality 34

Chapter 4: Dealing with Chemical Dependency and the Family: Practical Guidelines for Teachers and Child Care Workers 35
Introduction 35
The Disease of Chemical Dependency 35
Why Some Addicted Parents Do Not Seek Help 36
Practical Suggestions for Working with Parents of Children at Risk Due to Prenatal Substance Exposure 37
Initial Interview Ideas 39
Practical Suggestions for Working with Foster Parents/ Relative Caregivers 40
Selected References 41

Chapter 5: Assessment 43
Introduction 43
Definition of Assessment 43
Process of Assessment 43
Standardized and Nonstandardized Methods of Evaluation 43
The Difference Between Developmental Screening and Diagnostic Assessment 44
Guidelines for Screening and Assessment 45
Preschool Assessment Protocol 45
Parent Interview and Developmental History 45
Developmental Screening 46
Selecting a Developmental Screening Instrument 46
Authentic Assessment 47
Play Observation 48
Behavioral Observations 48
Observation Checklist: Assessing Relationship Function 48
Summary and Recommendations 48

Chapter 5: (continued)
Biological and Environmental Risk Factors Affecting Developmental Outcomes for Substance-Exposed Children 49
Suggested Instruments 50
Selected References 51
Guidelines for Screening and Assessment 52

Appendixes 53
Suggested Resources 54
State of California Resources 54
National Resources 55
Training Resources 56
Written Resources 57
Videotapes 58
Audiotapes 58
Free Reference Materials 58
Newsletters 58
Association of Regional Center Agencies 60
Regional Centers 60
Healthy Kids, Healthy California 62
Healthy Kids Centers 62
Terms Defined 63

Preface

Preschools and day care providers across the country are faced with escalating numbers of children at risk because they were exposed to drugs or alcohol before birth. The problems of meeting the special needs of such children are very real and a significant challenge to teachers and caregivers.

However, there is hope. Recent research and the experience of professionals have provided evidence that certain techniques are effective in working with these children. There is no typical profile by which they can be easily identified or grouped. The strategies used must be specific to the individual child and clearly and consistently applied.

The program *Just Kids* has been developed to help dispel myths, erase stereotypical labels, and provide effective and practical strategies to meet the needs of prenatally substance-exposed children in preschool or day care settings. It is the collective work of many experts in the field of prenatal substance exposure and child development. As resources were being developed, research investigated, and materials accumulated, individuals throughout the nation were contacted. Every contact produced another piece of research, additional relevant resources, and a rich variety of materials. The products of all these processes are this *Guide*, a companion training manual, and a 29-minute videotape in both English and Spanish. Although neither prescriptive nor mandatory, the techniques suggested in these materials are based on good child development practices and will be equally effective for both teachers and parents.

Teachers and child care providers can make a difference in the lives of children at risk by enhancing their repertoire of skills and knowledge and by working together. After all, these children, who need and deserve the very best we can offer, are truly "just kids."

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CHAPTER 1
PRENATAL SUBSTANCE EXPOSURE: INFORMATION AND FACTS

Introduction

The purpose of this section of the guide is to dispel some of the myths about children prenatally exposed to drugs and alcohol. Information provided below is based on the most current research. As more information and research on the long-term effects of prenatal substance exposure is available, added understanding of the children's needs will be possible.

A Look at the Problem

Caregivers throughout the country are faced with escalating numbers of preschool-age children at risk because of prenatal substance exposure. The media has presented images of these children as predominantly minority, having no conscience, difficult to handle, and with all kinds of learning and behavior problems. Recently, information about these children has changed. Research is now providing more realistic images and a hopeful prognosis, particularly for those children living in positive caregiving environments. However, this research does not negate the effect of prenatal substance exposure. It is still detrimental to the development of children to the extent that some children are acutely affected and need special consideration and services.

How Many Children Are Affected?

The National Association of Perinatal Addiction Research and Education (NAPARE, 1988) reports that 11 percent of all newborns have been exposed to drugs prenatally. That means that over one in 10 children or 375,000 infants are affected by prenatal substance exposure each year. There is no amount of drug or alcohol use during pregnancy that is guaranteed safe.

It is estimated that five percent of all birth defects are associated with the mother's use of alcohol during pregnancy. Over 50,000 babies are born each year in this country with Fetal Alcohol Effect or Fetal Alcohol Syndrome. Alcohol is the leading cause of preventable mental retardation in the United States. It is a devastating drug that can result in health and learning problems.

What Are the Effects of Prenatal Substance Exposure?

One of the greatest dangers a child prenatally exposed to drugs and alcohol will face is stereotyping or labeling. For example, use of the term "drug babies" is pejorative and should not be used. Stereotyping and labeling presume that all children prenatally substance-exposed are alike. Such a presumption is fallacious. In fact, children prenatally exposed to drugs and alcohol vary as much in ethnicity, socioeconomic backgrounds, skills, abilities, intelligence, and social competency as do all children.

Prenatal substance exposure is but one of many complex factors that affect the infant. It is difficult for researchers to sort out which risk factor is affecting the newborn. Many substance-using mothers are polydrug users—that is, they use more than one drug. Alcohol and cigarettes are drugs used by many pregnant women.

In general, women using drugs and alcohol during pregnancy risk having babies that are premature, low in birth weight, and small in size. These children are three times more likely to die, and the risk of Sudden Infant Death Syndrome is much greater than for children who were not exposed.

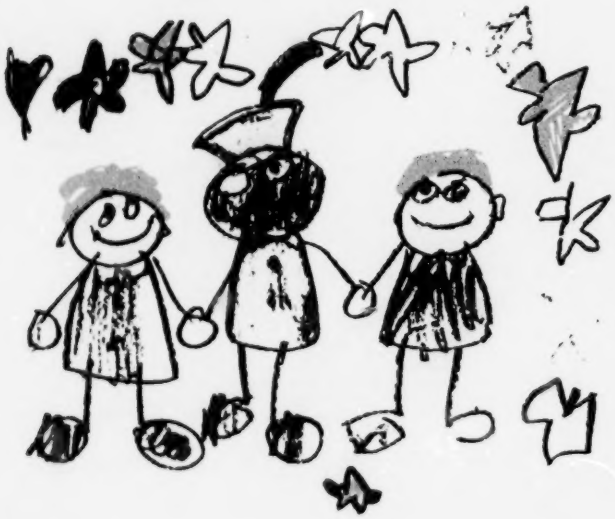
Children prenatally exposed to drugs and alcohol are at risk for developmental, learning, and behavioral problems. However, being at a greater risk than nonexposed children does not necessarily mean that prenatally exposed children will have difficulties. Many children who were prenatally substance-exposed show little if any residual effects in their preschool years. For those children who do demonstrate difficulties, there is great variability in their learning, skills, and behavior.

What Do the Children Look Like?

Children prenatally substance-exposed do not have a typical profile. Like all children, they come in many sizes, colors, shapes, and from varying ethnic and cultural backgrounds. The effects of drug exposure are varied, with some children prenatally substance-exposed being affected

minimally and others having more severe impairments. Motor development, speech, and memory are areas of development that appear to be affected by prenatal substance exposure.

Although not all prenatally substance-exposed children are affected to the same degree, teachers and caregivers have identified particular behaviors and learning characteristics seen in children. The behaviors and learning characteristics listed below should not be considered as absolutes or taken as stereotypes.



Behaviors and Learning Characteristics

Children at risk due to prenatal substance exposure may have a **heightened response to stimuli or exaggerated startle**. If there are many things going on in the environment, many things on the wall or hanging from the ceiling, many toys out, or if the classroom is noisy, the child may have difficulty. The stimulation that most children take in stride may prove very stressful for the child prenatally substance-exposed.

Behavioral extremes may range from quiet overcompliance to temper tantrums and uncontrollable behavior. One minute, the child may be playing with blocks and the next, knocking toys off the shelves. The child may appear irritable and agitated, always moving from one play area to the next without focus. Or, the child may be quiet and withdrawn, rarely noticed within the child care setting.

Difficulty with transitions from one activity to another has been reported in a number of children at risk due to prenatal substance exposure. Transitional times are hard for most children. For the at-risk child it may be even more difficult to handle the overstimulation and confusion in the environment. Transitions create a great deal of stress for the child.

At times children prenatally substance-exposed may have **difficulty staying on task** or playing with other children. They may be **easily distracted** by other events going on in the classroom. There is **minimal self-initiation** and **meaningful play** with other children. The substance-exposed child may not have learned how to play with other children.

Some children prenatally substance-exposed have **difficulties with visual-spatial relationships, integration** and **gross-motor coordination**. It may be hard for them to hold a crayon, jump, play with blocks, ride a tricycle, or participate in movement activities.

Memory may be impacted by prenatal substance exposure. The child may know a concept one day and lose it the next. A skill may seem to be mastered, then gone. The child will need to learn some information and skills a number of times before the information is integrated.

Speech and language delay are reported in children prenatally substance-exposed. They may have difficulty with word retrieval, decoding a word, sequencing a story, and processing information.

Children prenatally substance-exposed may **constantly test the limits**. They may not remember the rules from one day to the next. They may not learn from past experiences and may constantly need to relearn.

Difficulty interacting and **playing** with others is an area of concern. The substance-exposed child may not be able to respond appropriately to social cues. This inability may cause other children to exclude the affected child from play.

The following scenario should not be considered as "typical" of a child at risk due to prenatal substance exposure. It is necessary to remember that each child is unique in his/her behaviors.

When Tammy Comes to School

When Tammy walks into child care she is bigger than life itself. Tammy announces herself by running through the door and moving from area to area in the classroom. As she flies through an area, toys seem to come crashing down behind her. Tammy has an awkward walk and seems a little off balance. The transition from home to child care is not easy for Tammy.

After fifteen minutes, the room looks like a disaster area. The teacher feels like she has already put in her five and one-half hours. The day has only begun.

Breakfast is served and a group of children are sitting at the table. Tammy is hungry. She eats quickly. When Tammy has eaten her last pancake, she discovers there are none left. Upset, Tammy throws herself down on the ground and cries. She is not easily consoled. Tammy is not able to use words to get her needs met.

During group time the teacher reviews primary and secondary colors. Yesterday Tammy was able to identify the colors; today she does not remember. Tammy also forgot the rule about playing with the blocks: Before you move to another activity, you must put the blocks away. She just did not remember.

Four children are playing in dramatic play. Tammy is interested in their play and what they are doing. She notices Jeffery's hat. Tammy gets close to Jeffery's face and takes his hat. Jeffery is very angry and tells Tammy as much. Tammy does not appear to understand why Jeffery is angry.

It is time to go outdoors. Before they go outside, all children are expected to go to the bathroom. Several children are in the bathroom. Tammy begins to run around the room knocking toys off the shelves. The room is chaotic and busy. Tammy finds it hard to screen out all the stimulation. It is noisy; children are moving about in a small space, and the teacher is anxious.

While the children are outdoors, Tammy's mother returns to pick her up. Tammy is not ready to go home and runs to the other side of the playground. The teacher is exhausted and relieved to see Tammy go home. She does not know how Tammy's family is able to keep up!

Strategies for Working with Tammy

After observing Tammy for one week, the staff decided to reorganize the classroom to reduce the open space and clearly define areas. Instead of maintaining an open effect, the classroom learning areas were defined by using shelves to partition them off from the main traffic area. The number of materials, supplies, and equipment on the shelves was reduced to avoid overstimulation.

In order to help Tammy with transitions, the teacher began to greet Tammy and hold her hand as she entered the room. After saying good-bye to her mother/father, the teacher would ask Tammy, "Would you like to eat breakfast or play with the puzzles?" After Tammy made her choice, the teacher would help her get settled.

The staff found preparing Tammy for the next transition in the schedule was helpful. The teacher would walk up to Tammy, gently place her hand on Tammy's shoulder and say, "Soon it will be time to clean up; then you will need to use the bathroom." A second verbal warning was given one minute before cleanup and the lights were turned off for a few seconds while the room became quiet and the teacher announced cleanup time. One staff member was placed near Tammy to verbally coach her during cleanup and transitions.

Large-group time was eliminated for the time being and replaced by several small group activities. One such activity was a story time. Tammy would sit next to the teacher during story time. When the story was over, the teacher would ask Tammy, "Would you like to play with the blocks or paint a picture?" Again, Tammy was directed toward a specific activity.

The staff noticed that Tammy would know and appear to understand a concept one day, then not remember it the next. A plan was developed that included see it, hear it, say it, and touch/do it. For example, Tammy did not remember the color red.

The teacher had a red apple to show Tammy. She then said, "This is a red apple. Can you say, 'red apple'? Would you like to hold the red apple?" Then the teacher could say, "Can you find something else in the classroom that is red?"

During play time Tammy sometimes gets too close to other children, and they want to push her away. A staff member reminds the children to use words to tell Tammy she is too close and to ask her to please move back. Tammy is encouraged to use words when she wants to play with other children. The teachers model using words. For example, the teacher might say, "May I come into the playhouse and play with you?"

Before going outdoors, the children are asked to use the bathroom. The teacher takes three children at a time to the bathroom. When six children are finished using the bathroom, the first group goes outdoors with an adult. This procedure reduces the waiting time, confusion, and noise. The teacher gives Tammy a special job. Tammy will hold a younger child's hand, or carry a sand toy, or hold the teacher's hand. The transition is structured with a beginning, middle, and end.

The teacher and Tammy's mother developed a plan for the time when Tammy is picked up. The mother comes at the same time each day, unless previously arranged. Tammy is reminded when it is almost time for Mom to pick her up from school, and a staff member assists Tammy in collecting her belongings so that she is ready for Mom. In addition, the staff person will talk with Tammy about her plans for the afternoon. This talk gives Tammy an opportunity to prepare for another change in her day and have some sense of control over the changes.

Working as a team, the staff has seen tremendous changes in Tammy's behavior and school success. The team's working as a partner with the mother has helped transfer Tammy's success to home.

There are many Tammys in child development programs. They are at risk for having developmental delays, poor sense of self, difficulty getting along with others, and feelings of being unsuccessful as learners. With a developmentally appropriate child care setting that is sensitive to family and cultural dynamics and an understanding of the child's needs and abilities, the teacher can provide an enriching environment that will build upon the child's successes. The following sections of this guide will offer ideas and suggestions for working with at-risk children.

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HOW DO DIFFERENT DRUGS AFFECT THE FETUS?

Alcohol—Use during pregnancy may result in babies who have low birth weight and heart problems, may be mentally retarded or hyperactive, and have learning problems. Severe cases have abnormally small heads, low nasal bridges, small eyes, flat midfaces, short noses, indistinct philtrums, and thin upper lips. Fetal Alcohol Syndrome (FAS) is the leading known cause of **preventable** mental retardation.

Tobacco—Use during pregnancy may cause premature birth, small babies, and low birth weight.

Marijuana—Use during pregnancy may result in babies who have more lung and other infections, have low birth weight, are small in stature, and are more likely to be premature.

Crank, Speed, Uppers, Amphetamines, Benzadrine—Use during pregnancy may result in babies who are more likely to be premature, may not grow properly, may be born small, are more likely to be born addicted to drugs, and may go through withdrawal which may cause permanent damage or death. These drugs are stimulants. Children may have behavior problems later in life.

Valium, Sedatives, Downers, Barbiturates—Use during pregnancy may result in babies born with cleft lip and palate or other birth defects. Babies born addicted may go through withdrawal and have later problems.

Cocaine—This drug and crack, a stronger version of cocaine that is smoked, have several harmful effects. Use during pregnancy may cut off the blood supply to the baby because the mother's blood vessels are constricted, resulting in death or stroke before birth. Babies may have small heads, be small in stature, and be more likely to be born prematurely. Babies may be born addicted, though there is no known withdrawal syndrome. Infants have difficulty with managing states (tremors, etc.). Children may have behavior problems later in life.

Heroin, Methadone, Demerol, Analgesic—Use during pregnancy may contribute to premature birth, low birth weight, small stature, infant addiction, and withdrawal. Babies may have problems eating and breathing. Children may have behavior problems later in life.

PCP, Angel Dust, LSD, Mescaline—Use during pregnancy may result in babies born with birth defects and addiction to drugs who have behavior or learning problems later in life.

All women using drugs during pregnancy risk miscarriage and stillbirth. Babies born substance-exposed are more likely to die from Sudden Infant Death Syndrome during the first year of life. **There is no guaranteed safe amount of drugs or alcohol!**

MYTHS AND FACTS ABOUT SUBSTANCE-EXPOSED CHILDREN

MYTH: Children prenatally exposed to drugs are predominantly members of ethnic minorities.

FACT: Research indicates that children with prenatal drug exposure come from diverse socioeconomic and cultural backgrounds.

MYTH: Children prenatally exposed to drugs and alcohol will have learning and behavior problems.

FACT: There is great variation in learning and behaviors in children prenatally substance-exposed. Many children do not appear to have learning or behavior problems.

MYTH: Drug and alcohol use during pregnancy occurs primarily among women of low-income minorities.

FACT: Women who use drugs/alcohol during pregnancy cross all ethnic and socioeconomic groups.

MYTH: There is little hope for children prenatally substance-exposed.

FACT: With a healthy environment and consistent care, the prognosis for children at risk because of prenatal substance exposure is very good.

MYTH: There is a "typical" profile for a "substance-exposed" child.

FACT: All children are unique in their development and behaviors. There is no typical profile for children prenatally exposed to drugs/alcohol.

THE CHILD AT RISK:
CHECKLIST OF CHARACTERISTICS[1]
(Behaviors You May Observe)

Developmental Characteristics:*

- Has difficulty organizing play.
- Does not self-initiate often.
- Demonstrates little follow-through in play, learning, and self-help activities.
- Appears more distracted and less focused than peers.
- Has difficulty with spatial relationships.
- Demonstrates poor motor coordination.
- Shows only sporadic mastery (needs to relearn again and again).
- Demonstrates low stress thresholds.
- Is overreactive to stimuli.
- Lacks close relationships to adults.

Behavioral Characteristics:*

- Exhibits behavioral extremes.
- Is easily over-stimulated.
- Shows low tolerance for change.
- Tests the limits constantly.
- Has difficulty reading social cues.
- Has difficulty with peer relationships.

Learning Characteristics:*

- Manifests a delay in language development.
- Has sporadic mastery of perceptual-spatial-motor tasks.
- Demonstrates inconsistent problem-solving strategies.
- Experiences difficulties with auditory processing and word retrieval.
- Demonstrates decreased capacity to initiate and organize play.
- Shows decreased focused attention and concentration.

* All of these characteristics must be weighed against a careful consideration of the child's ethnic, cultural, and unique family background and experiences.

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[1]Adapted with permission from Marie K. Poulsen, *Schools meet the challenge: educational needs of children at risk due to prenatal substance exposure.* Sacramento: Resources in Special Education, 1992, pp. 21–23.

CHAPTER 2
HELPFUL TEACHING STRATEGIES THAT WORK WITH CHILDREN AT RISK DUE TO PRENATAL SUBSTANCE EXPOSURE

Introduction

Teachers and child care providers have expressed concern about providing for the needs of children at risk due to prenatal substance exposure. The challenge is meeting the needs of other children in a classroom or child care setting while providing for the needs of the at-risk child. This chapter will present some ideas that teachers and child care providers have used successfully. It will also act as a reminder that the best practices are good for all children. Much of this section is based on *Today's Challenge: Teaching Strategies for Working With Young Children At Risk Due to Prenatal Substance Exposure*, which was developed by the Los Angeles Unified School District. Included are protective factors that keep children from feeling overwhelmed and unable to cope, and, facilitative factors that foster the development of close teacher-child relationships, self-esteem, self-mastery, and problem solving.

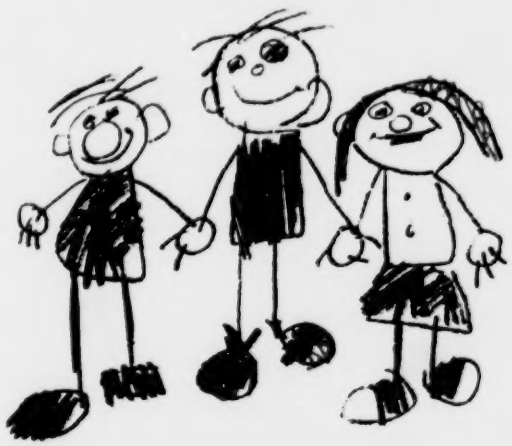
Protective Factors

Daily Routines

Greetings and good-byes at the beginning and ending of the day are important to the well-being of the child and the parent. When a parent and child arrive at school or child care facility, a greeting helps them feel important and cared about. For some families the teacher must make an extra effort in greeting that includes moving near that parent, maintaining eye contact, and conversation. The family at risk especially needs this expression of care and concern from another adult.

At times young children need **extra nurturing** as they say good-bye to their parent, relative, or foster parent. The child may need to be held by the hand or on the lap, or receive a reassuring touch from the teacher. A good-bye window where a child can run, look out, and wave good-bye to their loved one is helpful. Some children need a **transitional object from home**. This object may be a coat, picture, blanket, or any other item that bridges the gap between home and school. A transitional object should provide comfort for a child when separated from parents.

Pick-up time can be especially difficult for a parent and child, particularly when the parent arrives and the child begins to cry, "I don't want to go home." Teachers and child care providers must **reassure a parent** that such behavior is normal for children. They are enjoying what they are doing and want to continue. The family at risk needs particular reassurance because the parent has usually been faced with feelings of inadequacy. When possible, warn the child a few minutes in advance that it is almost time to go home. Assist the child in gathering work together so that it will be ready when it is time to leave. **Talk to the child in a positive way** about going home and coming back the next day. Sometimes sending the child home with an object from school is helpful. A picture of the classroom can be an effective transitional object.



A classroom **routine** that is predictable and reliable is important for at-risk children as they learn self-control and the ability to anticipate future events. A child gains a sense of control over the day and begins to develop a sense of mastery over the environment. It is important that the routine follows the same sequence each day. However, the amount of time spent on each

activity may be extended or limited according to the needs of the child.

Rituals are as important as routines. Rituals are common practices or ceremonies included in the daily curriculum. For example, reciting the same poem every day before nap time is a ritual. **Rituals** provide children with a sense of orderliness and predictability. Rituals strengthen a child's sense of self-control and mastery over the environment.

Staff

Consistent staff is essential for predictability, so a child can develop trust and feel secure. The child at risk is particularly sensitive to new and different people in the environment. Whenever possible, a child should be **prepared for a staff change**. For example, during group time the day before you are leaving, you could tell the children that another teacher named "Mary" will be their teacher. Mary will read a story, just like "I" do. Mary will play outdoors just like "I" do. Perhaps engage the children to come up with other things Mary will do with them. Be sure to prepare Mary. Have Mary follow the routine and reassure the children that their teacher will be back. It is helpful for staff members to put their pictures on the wall or in a book. Children can refer to the pictures when one of the adults is not at school.

There will be times when other professionals will be entering the classroom or child care to interact with the children. These adults should develop a predictable routine for reintroducing themselves into the classroom. The regular staff can help by preparing the children for the visit. A pictorial calendar of events, placed on the wall, is helpful. A group time at the beginning of the day may be used to discuss routines, rituals, and special events. A plan of action will reduce chaos and confusion.

A number of at-risk children will have a history of **poor attachments** because of an inconsistent home environment and not having their needs met. It is particularly important for staff to recognize that children who are insecurely attached have a difficult time trusting adults. The first step in promoting attachment is to recognize that each child comes into the classroom with unique socio-economic and cultural life experiences and biological characteristics. Each child has strengths and weaknesses. No two children react exactly the same to the same situations .

Through rituals and routines children begin to anticipate what will happen next. They learn that the world is predictable and they have a sense of control over their world. Through **positive interactions with adults and peers,** the child learns that the world can be a good place. As the child begins to have a sense of control and finds that adults can be trusted, healthy attachment develops.

It is important that staff members understand that they are **role models** for the children in the program. Staff behavior must reflect **respect for each child's work** and play space. For example, if a child is talking with another child, wait before interrupting. When waiting is not possible, say, "Excuse me; may I speak with you for a moment?" Do not unpredictably appear or disappear. Be sure that demands are realistic. It is very important to model the behaviors you would like to see repeated.

Acknowledging a child's feelings, modeling the behavior you want to see and providing the child with an opportunity to practice the behavior help the child learn. In responding to a child's misbehavior, the first priority should be to acknowledge what the child seems to want before dealing with the misbehavior. Helping the child put his/her wants into words will enable the child to express feelings verbally. Remember, children behave and misbehave for a reason, even though the reason may not be apparent.

Mutual discussions between teacher and child about feelings, behaviors, and experiences promote positive relationships with others. **Talking about feelings** and behaviors in an understanding manner validates the child's experiences. Allowing children the opportunity to express themselves gives them permission to have feelings and leads to the increased ability to distinguish between wishes/fantasies and reality. Verbal expression helps children integrate past and present events into a total experience. This process leads to the child's increased ability to gain self-control, change their behavior, and express their feelings.

Transitions

Transition times are difficult for young children. These are times during the day when children are

moving from one activity to another. Over-stimulation and much confusion result from the noise and chaos that usually accompany transition. The at-risk child may show signs of stress during transitions.

The first consideration is a look at the daily schedule. Are there too many transitions during the day? Can this number be reduced? An example of a typical daily schedule is:

7:30 - 8:30	Free play
8:30 - 8:45	**Group transition**—cleanup
8:45 - 9:15	Breakfast
9:15 - 9:30	**Transition**—Clean up from breakfast.
9:30 - 9:45	Large group
9:45 - 10:50	Small group activities
10:50 - 11:00	**Group transition**—Clean up to go outdoors.
11:00 - 11:50	Outside
11:50 - 12:00	**Clean up outdoors.**
12:00 - 12:15	Indoors—large group activity
12:15 - 12:30	Children leave group four-at-a-time to wash up and prepare for lunch.

This particular schedule is for a part-day program and look at the number of transitions! Can you think of ways to reduce the number? The following schedule reduces the number of large group transition times.

7:30 - 8:45	Breakfast and free choice activities
8:45 - 9:00	**Cleanup**
9:00 - 9:15	Large group to go over the day (**plan, do, review**)
9:15 - 11:50	Indoor/outdoor choice and planned activities
11:50 - 12:05	**Cleanup**
12:05 - 12:20	Review the day.
12:20 - 12:30	Children leave group four-at-a time to **wash up** and prepare for lunch.

This schedule includes breakfast as a learning activity during free-choice time. There is one large group to go over the day's events, talk to the children about the activities that are available, and make a plan for the day. The small group activities may include music, movement, reading, manipulatives, playing house, blocks, story time, science, or other activities. It is much easier for young children to play and learn in a small-group setting.

Transition time should be seen **as a learning activity**. With this view transition has a structure that is clearly defined for the child. It has a beginning, middle, and end. A popular transition-time activity follows:

> It is group time and the teacher would like to move all the children outdoors. There are two aides, one teacher, and 24 children. The children are three-, four-, and five-year-olds. The teacher says: "Will all the children who are three go outside with Dan." After they move outdoors, "Will all the children who are five go with Sue to get the balls. All the four-year-olds come with me and we will unlock the bike shed."

This activity has structured the transition in such a way that the youngest children are outdoors first. They usually have more difficulty waiting, but not necessarily so. The older children were given specific tasks and responsibilities. Fewer children will be moving outdoors at the same time and chaos is reduced.

Learning Environment

The **learning environment** may increase or reduce the number of negative behaviors, depending on the design and decoration. A room using soft, soothing colors is desirable. Light blue is an

example of a soothing color. Whenever possible wood should be natural, with a finish coating for protection. A play area that is clearly defined provides a visual cue for the child. For example, the block area may have child-size shelves on both sides and an area carpet. Such an arrangement clearly defines the area and use of the equipment. Play areas should accommodate four or five children. Sometimes decorations contribute to overstimulation. Too many items on the shelves may be distracting and overstimulating. Be aware of decorations hanging from the ceilings and on the walls. If there are particular areas where problems occur, observe and use the information to change the area. One example of a problem area would be a part of the room where lots of running takes place. Moving the furniture around can reduce open areas that encourage running. A flexible room arrangement in a classroom or child care setting is one in which materials and equipment can be removed or added as needed.

Change

Change is difficult for most young children. The child at risk due to prenatal substance exposure may have more difficulty with change than the typical child. Prepare the children for changes in the room arrangement, staff, and routine. Whenever possible have the children participate in the planning when there is a change.

Rules

Classroom rules must be clearly stated and limited. If there are too many rules, the number of misbehaviors increase and the child's opportunities to explore, problem solve, and actively engage in the environment become limited. Classroom rules may include: Be safe, respect others and materials, and put things back when you are finished. Visual aids reinforce where items belong in the classroom. For example, a laminated picture of Legos on the shelf is a visual reminder of where the Legos belong. The goals are to reduce external means of controlling children and to increase the child's intrinsic motivation to control himself/herself.

Group Size

Children at risk are more successful when the group size is small and the adult/child ratio is high enough so that children's needs are met. As children begin to trust and predict, they form attachments. Caring, consistent adults in the classroom or child care setting promote attachment. At-risk children need high adult/child ratios as they learn appropriate ways to cope, interact, and play. When a smaller group size is not an option, the room may be arranged so that the numbers of children in each area are limited. With planning, activities can be organized as small group activities with fewer children in a play area.

Play

Play is the most important part of a preschool or child care learning experience. Through play children learn to solve problems, work in groups, create, explore, discover, communicate, and become symbolic thinkers. Adults can facilitate play by providing a rich learning environment that includes props and open-ended activities. Adults can participate with children in play by sharing, encouraging, questioning, clarifying, and expanding. Play can be used by a child to make sense out of life experiences, explore and manipulate the environment, and cope with and work out frustrations. Plenty of time should be allowed for play. Play is an important part of the curriculum.

Curriculum

The curriculum itself must be viewed in broader terms. Janet Gonzalez-Mena and Diane Eyer describe a broad-based curriculum in *Infants, Toddlers, and Caregivers.*[1] This concept is easily transferred to the preschool setting. The curriculum becomes all of the experiences of a child from the time they leave home until they return. Each activity is an important part of the curriculum as the at-risk child becomes a competent learner. For example, earlier in this section, breakfast was included as a learning activity. Children learned to pour, spread, use utensils, verbalize wants, and socialize.

[1]Janet Gonzalez-Mena, and Diane Eyer, *Infants, toddlers, and caregivers.* Mountain View, Calif.: Mayfield Publishing Co., 1989, p. 43.

Observation

Observation of the at-risk child is particularly important. Ongoing observation that documents skill acquisition, strengths, and development is part of a quality child development program. A skilled observer will notice subtle changes in a child's behavior, health, and development. Documenting ongoing observations using anecdotal recording, health checklist, developmental assessment, and skill acquisition checklist provide important information about the health, development, and well-being of the child. A comprehensive assessment is ongoing and provides a view of the whole child. Parent(s) should be included in the assessment as reporters of the child's skills and abilities. Observation and assessment will be dealt with in more depth in Chapter 5.

Facilitative Factors

Respect

Children learn respect by observing the interactions of adults and children in the environment. When adults model respectful behavior toward children and other adults, they provide a framework for relationships with others. When adults are nurturing and considerate of a child's work and play, the unspoken message to the child is, "You are important; what you do is important." In turn, self-esteem is strengthened. For example, if a child is busy finger-painting and it is almost cleanup time, let the child know that in five minutes it will be cleanup time. A next step is to ask, "Do you want to finish your picture now or do you want to find a place to put it so that you can finish it later?"

Relationships

Relationships are an important part of every child's life. The most significant and important relationships are developed within the family, school, with caregivers, and friends. These relationships are formed through interactions and reflect experiences with important issues like trust, protection, availability of parents and caregivers, and their responsiveness to the child's needs. Each child has a history of positive and negative experiences. If the child's experiences are primarily positive, the child is more likely to feel good about who they are and develop responsive reciprocal relationships.

When a child's care is inconsistent, inadequate or rejecting, it impacts the child's ability to trust, feel safe, and develop significant positive relationships. At times it fosters mistrust, fear, suspicion, apathy, or anger towards others.

A teacher/child care provider fosters the development of significant positive relationships when they are responsive to the child's needs and offer a nurturing consistent environment.

Feelings

A child at risk may experience numerous stressors (internal or external) in daily living. Individual children respond differently to the same stressful events. A child may respond differently from one day to the next. The emotional turmoil a child goes through during times of stress can be difficult for others in the same environment. The resulting behaviors may lead to frustration for the adult attempting to encourage positive behaviors.

The teacher/child care provider can assist the troubled child by encouraging the child to talk about feelings, acknowledging what the child seems to want before dealing with a behavior, and recognizing the child's feelings. Teachers need to develop a sensitivity to different stressors and the impact they have on a particular child, and to be responsive to the child's needs by reducing those stressors whenever possible.

Mutual Discussion

Mutual discussion takes place when a teacher/child care provider validates the child's behavior and experiences, and sets up an accepting atmosphere. This discussion is conducted in a nonjudgmental, empathetic fashion. When a child is permitted to express feelings, the ability to distinguish between wishes/fantasies and reality is increased. Verbal expression increases the child's ability to integrate past and present events into meaningful experiences. The process of verbalization leads the child to learn to modulate behavior, gain self-control, and express feelings in an appropriate manner.

Role Model

Observing how others behave in a situation is one way that children learn how to behave. The teacher/child care provider is an important model that children are likely to imitate. The more important a person is in the child's life, the more likely that the child will imitate that person's behavior. Adults must demonstrate the behaviors that they would like to see repeated through interactions and reactions.

Peer Sensitivity

The child at risk learns to be sensitive to others as others are sensitive to the child. When a child's needs are met on a consistent basis, energy can be focused on meeting the mutual needs of a relationship.

Decision Making

A child learns to accept responsibility when given choices and learns to assume responsibility for the choices made. Adults can support children as they learn to make decisions by encouraging mutual discussion and verbally thinking through the choices. Decision making increases the child's self-esteem, problem-solving mastery, and development of moral values. It also expands the child's social, emotional, and intellectual growth. When a child makes a poor choice, it is an opportunity to learn and make a better choice the next time.

Home-School Partnership

Parents/caregivers are an important part of the child's education. When the home is recognized as an important part of the curriculum and mutual discussions between the parent/caregiver and teacher/child care worker are ongoing, the educational process is strengthened. The home/school partnership promotes long-term, positive educational experiences and expands the understanding of ethnic, cultural, and family beliefs.

Transdisciplinary Model

Children at risk and their families are best served when all individuals working with the child work together. The most important members of this team are the family and teacher/child care provider. Teachers/child care providers must be allotted time to meet and plan with other professionals and the family. The goal is to work together to develop a comprehensive plan to meet the special needs of the child and family.

TEACHING STRATEGIES[1]
A. LEARNING

Learning occurs in a developmental framework. Development is an internal process in which the child is consistently organizing and reorganizing experiences within a continuum of stages. Movement through the stages is not an automatic passive activity. From birth, a child who has not been exposed to drugs/alcohol has the potential to selectively attend and respond to stimuli and take the initiative to explore and control the environment.

Competency to perceive and explore the environment can be damaged in the child prenatally exposed to drugs/alcohol. Concrete experiences, decision-making and problem solving within a nurturing environment as well as positive interactive communication help to build the foundation for development. This foundation promotes self-esteem, competence and motivation for new learning.

NORMAL LEARNING DEVELOPMENT	LEARNING BEHAVIOR OF AT-RISK CHILDREN	TEACHING STRATEGIES
The child:	The child:	Teaching staff:
• learns to focus on tasks in play situations.	• may easily be distracted by sounds, people and movement.	• recognize stressors in child's environment and attempt to minimize them.
• uses numerous problem solving strategies.	• may have poor visual scanning.	• provide support and emotional reassurance.
• shows sustained attention in individual and small group activities.	• may show decreased trial and error.	• reduce classroom interruptions as much as possible.
• develops a sense of task completion.	• may show decreased problem solving strategies.	• limit number of objects in room.
• steadily progresses in the acquisition of skills.	• may have decreased attention and concentration.	• establish classroom routines with minimum number of transitions.
• learns to delay immediate needs and to conform to the social expectations of the classroom.	• may show perseverative behavior in problem solving.	• model alternative strategies.
• is able to end a preferred activity and start a teacher directed activity.	• may show decreased task completion.	• direct child to watch another child who is using a successful strategy.
• demonstrates sporadic/intermittent mastery of skills in new learning situations.	• may need longer time to complete task.	• consider developmental level of child.
• acquires pre-academic concepts through incidental learning.	• may give up easily when confronted by problem solving situations.	• recognize preschoolers may need to sit in adult's lap.
	• may be easily frustrated and become irritable in problem solving situations.	• recognize preschoolers may need to sit next to an adult.
	• may be unable to do task previously mastered.	

[1] Reprinted with permission from *Today's challenge: teaching strategies for working with young children prenatally exposed to drugs/alcohol.* Los Angeles: Los Angeles Unified School District, 1990, pp. 8–24.

NORMAL LEARNING DEVELOPMENT	LEARNING BEHAVIOR OF AT-RISK CHILDREN	TEACHING STRATEGIES
The child:	The child:	Teaching staff:
	• may be unable to take turns.	• use physical, concrete and verbal cues to direct or redirect child in task or activity.
	• may not remain seated in circle or at the table with the other children.	• recognize and consistently praise child's attempts and accomplishments.
	• may withdraw from a lack of social and environmental stimulation and may learn to become nonresponsive.	• ask child to verbalize steps of a task.
	• may not have regular play/rest cycles or patterns.	• provide verbal cues (talk the child through task) if child is unable to verbally give steps of task.
	• may become upset with changes in routine.	• provide the child with an opportunity to take turns with peers and adults.
	• may have difficulty with changes/transitions.	• model taking turns.
	• may be unable to end or let go of preferred object or activity.	• provide attention and time to children who are behaving appropriately.
	• may demonstrate sporadic/ intermittent mastery of skills over prolonged period of time.	• protect child from the overstimulation of intrusive persons or noisy environments and from the understimulation of a bland social and environmental experience.
	• may not learn incidentally.	• provide the child a schedule of play and rest activities to help develop regular patterns.
		• alert the children routinely 1-2 minutes ahead of time that the activity will soon be over.
		• talk about the next activity before entering into the activity.

NORMAL LEARNING DEVELOPMENT	LEARNING BEHAVIOR OF AT-RISK CHILDREN	TEACHING STRATEGIES
The child:	The child:	Teaching staff:
		• allow adequate time for the transition activity.
		• guide the child through the transition and into the next activity.
		• recognize stressors in child's environment and attempt to minimize them.

B. PLAY

Play is the area where a child integrates experiences with communication, social/emotional and motor skills. Through play, a child can learn to understand self and relationships to others and the world. As a child grows and matures, play involves increased communication skills, attention, concentration and concept development. Strategies for play are important because a child prenatally exposed to drugs/alcohol is at risk for poor play skills.

NORMAL PLAY DEVELOPMENT	PLAY BEHAVIORS OF AT-RISK CHILDREN	TEACHING STRATEGIES
The child:	The child:	Teaching staff:
• learns to organize own play.	• may show decreased spontaneous play with increased aimless wandering.	• recognize stressors in child's environment and attempt to minimize them.
• can independently select materials and focus on them in an appropriate manner.	• may not organize own play, appear perplexed and confused and cannot select materials and focus adaptively.	• give child toys and/or areas in the classroom that are child's alone, and do not have to be shared.
• engages in play which is functional, representational, and sequential.	• may be easily over-stimulated by too many things and people and by too much noise, movement and excitement.	• recognize that the child may not have had consistent play objects in child's environment.
• progresses from parallel to interactive play.	• may show delay, discontinuity and disorder in representational play.	• find out what is available for the child in child's home.
• joins in play with other children.	• may have difficulty joining others in play.	• decrease/regulate amount of toys for child.
• initiates interactive play.		
• takes part in and initiates dramatic play.		

NORMAL PLAY DEVELOPMENT	PLAY BEHAVIORS OF AT-RISK CHILDREN	TEACHING STRATEGIES
The child:	The child:	Teaching staff:
• is able to sequentially move through a play activity.	• may not initiate appropriate interactive play. • may not initiate dramatic play.	• will respond to and follow the child's lead in play. • will model toy choices for child with correct verbal cues. • verbally and physically model play with toys. • provide opportunities for child to play interactively in a safe environment with the adult available for assistance and reassurance. • provide child with opportunities to take turns with peers and adults. • provide time to model interactive play. • provide child with support and encouragement during play. • initiate and model dramatic play with child. • respond to child when child initiates dramatic play by verbal responses or by playing with the child.

C. SOCIAL/EMOTIONAL

When interactions between the drug/alcohol exposed infant and caregivers result in poor attachment, rejecting or inconsistent care, the child is at greater risk for developing mistrust, suspicion, and fear. These attitudes may carry through to later stages of development and manifest themselves behaviorally. Exaggerated behavior patterns are often the way a child copes with a situation that is overwhelming. Each child must be made to feel emotionally safe to attempt new learning. It is important to establish a responsive, nurturing environment conducive to active learning in which the child may build a positive self-concept.

NORMAL SOCIAL/ EMOTIONAL DEVELOPMENT	SOCIAL/EMOTIONAL BEHAVIOR OF AT-RISK CHILDREN	TEACHING STRATEGIES
The child:	The child:	Teaching staff:
• develops and maintains healthy attachments.	• may not use adults for comfort, play, approval, or object attainment.	• recognize stressors in child's environment and attempt to minimize them.
• separates from parent when trust has been established.	• may go from one to another, showing no preference for a particular adult.	• provide opportunities for contact, mutual touch and smiling throughout the day.
• learns to look for and respond to adult approval.	• may not look to adult for recognition of a job well done.	• respond to specific needs of child with predictability and regularity.
• learns to respond to gestural/ verbal praise and setting of limits by teacher.	• may display negative feelings about self and abilities.	• need to address child by name, elicit eye contact and/ or touch child before giving verbal command.
• forms attachment to teacher.	• may not respond in any way to verbal praise from adult.	• talk child through to consequence of child's action.
• learns to socially signal desires and needs.	• may ignore verbal/gestural limit setting.	• provide the child with explicitly consistent limits of behavior.
• learns to interpret and respond to social cues of adults.	• may engage in negative attention-getting behavior.	• take every opportunity to develop teacher-child relations.
• learns to read and respond to social cues of peers.	• may show decreased compliance with routine simple commands.	• use close proximity and gestures.
• shows broad range of emotions, including pleasure, anger, fear, curiosity and assertiveness.	• may show indiscriminate attachment to all adults.	• respond to muted signals and give child a verbal explanation of child's behavior.
• shows a balance in emotions.	• may display overly compliant behavior towards adults and peers.	
• learns to regulate own inner state.		
• responds to emotions of others.		

NORMAL SOCIAL/ EMOTIONAL DEVELOPMENT	SOCIAL/EMOTIONAL BEHAVIOR OF AT-RISK CHILDREN	TEACHING STRATEGIES
The child:	The child:	Teaching staff:
• learns to develop an independent sense of self and responsible behavior resulting in self-esteem.	• may not signal desires by giving eye contact, gesturing or vocalizing.	• move close to child, look at child and help child to read teacher's cues by explaining to child what the teacher's look, body language, or gesture means.
• develops a strong self-interest.	• may not be able to read teacher's cue/look.	• label expression of emotions so child learns to identify those emotions.
	• may show a restricted range of emotion: - overreacts to "no" by total withdrawal. - rarely smiles, laughs, or shows joy. - demonstrates lethargy, listlessness, flat affect. - exhibits clingy behavior with adult.	• use books, pictures, doll play and conversation to explore and help child express a range of feelings.
	• may not express/show feelings of fear, grief, worry, anger.	• allow, identify and react to child's expression of emotions: - pleasure - curiosity - protest - dependency - excitement - love - anger - fear - self-assertion
	• may withdraw, seem to day-dream or not be there.	• model full range of emotions for child.
	• may have poor inner controls/ impulsive.	• communicate with caregiver and find out if there has been an upset in the home or any change of routine in the home, any family emergency or if the child's sleeping pattern has changed.
	• may have difficulty with modulating behavior (mood extremes, e.g., giggles turn to screams).	• assist child in gaining control by: - getting eye contact - sitting next to the child - verbal reassurance - physical comfort, i.e., teacher rubs child's back.
	• may remain clingy and dependent on teacher for decisions and daily living activities for extended periods of time.	• use stories, puppets and role-play to develop empathy for others.
	• may overreact to separations from primary caregiver.	
	• may show some lack of self-awareness as an individual.	
	• may not show concern or empathy towards others.	

NORMAL SOCIAL/ EMOTIONAL DEVELOPMENT	SOCIAL/EMOTIONAL BEHAVIOR OF AT-RISK CHILDREN	TEACHING STRATEGIES
The child:	The child:	Teaching staff:
		• provide daily opportunity for child to practice independent feeding, dressing, bathing, toileting and play skills with tolerance for messiness and dawdling. • provide child with a daily opportunity to make small decisions and limited choices in play and/or self-help activities. • have activities centered on the child as an individual. • provide spaces and objects in classroom that are for each child (cubbies with names, personal toys from home and individual picture books).

D. COMMUNICATION

The child's capacity to communicate evolves from early mother-child interaction. The development of a child's language depends on the child's ability to receive, understand, integrate and express meaningful experiences. The child learns to use gestures/words to express feelings, communicate wants and describe experiences. A child learns language best through social interaction with significant individuals and through active exploration of the environment.

NORMAL COMMUNICATION DEVELOPMENT	COMMUNICATION BEHAVIORS OF AT-RISK CHILDREN	TEACHING STRATEGIES
The child:	The child:	Teaching staff:
• is able to follow directions appropriate for his developmental level (simple commands, multiple commands).	• may have delayed receptive and expressive language.	• recognize stressors in child's environment and attempt to minimize them.
• learns to communicate simple wants and needs, name objects, express feelings at appropriate developmental levels and describe experiences and events.	• may be unable to follow directions that are appropriate for the child's developmental level.	• create a stable environment where child feels safe to express feelings, wants, and needs.
• is able to use pragmatic language.	• may have prolonged infantile articulation at preschool level.	• use "hands-on" activities to reinforce child's language.
• learns to initiate appropriate interactions with peers.	• may not use attained language to communicate feelings, wants, and needs.	• use eye contact, give simple one-step directions, and gradually increase number of steps in a direction.
	• may be unable to verbalize needs, wants, and fears and expresses them through behavior such as banging, stomping, and shouting.	• map language in the context of the activity.
	• may show listlessness, passivity, and/or lack of social awareness.	• provide names of people, pets, food items, body parts, objects, feelings and events in the process of conversation.
	• may observe rather than verbally engage with peers in play.	• immediately respond to beginning attempts at verbal communication.
	• may inappropriately initiate interaction with peers by: - hitting - pushing - biting - swearing - negative verbal remarks.	• investigate child's behavior by asking child questions to discover what child needs, wants, or fears. • acknowledge the needs or wants or fears of the child.

NORMAL COMMUNICATION DEVELOPMENT	COMMUNICATION BEHAVIORS OF AT-RISK CHILDREN	TEACHING STRATEGIES
The child:	The child:	Teaching staff:
		• provide strategies to child of how to appropriately express child's needs, wants, or fears.
		• acknowledge attempts by child to cooperate and interact with other children.
		• recognize negative behavior may be a signal of child's unmet needs.
		• reflect child's feelings.
		• verbally direct child's behavior.
		• verbally cue child's attempts toward adaptive behavior.
		• ignore inconsequential verbal behavior.
		• verbalize expected behaviors.
		• redirect behavior.
		• remove child and help child calm self.
		• provide child verbal language to use with each other.
		• will intercede with extra support for child who has used best developmental skills to resolve conflict without success.
		• set consistent limits on inappropriate behavior, but allow for expression of feelings.
		• provide time to talk with child about emotions.

E. MOTOR

Motor and spatial development stems from the interplay of a number of factors beginning prenatally and continuing through early childhood. Any major interferences along this continuum can result in motor/spatial impairment. As a result of prenatal exposure to drugs/alcohol, the child may exhibit varying degrees of fine, gross motor and spatial relationship delays.

NORMAL MOTOR/SPATIAL DEVELOPMENT	MOTOR/SPATIAL BEHAVIOR OF AT-RISK CHILDREN	TEACHING STRATEGIES
The child:	The child:	Teaching staff:
• has awareness of child's body placement in relationship to the environment.	• may trip or stumble without apparent cause.	• recognize stressors in child's environment and attempt to minimize them.
• has age appropriate gross motor skills.	• may have difficulty with gross motor skills (e.g., swinging, climbing, throwing, catching, jumping, running, and balancing).	• verbally remind child of obstacles.
• has awareness of space relationships among objects in relation to self.	• may walk into stationary or moving objects.	• guide child through motor activities that emphasize skills of rhythm, balance, and coordination.
• has awareness of space relationships among objects in relation to each other.	• may move too close or too far away from another object.	• model and guide child in learning to control child's body through songs, games, and play.
• is able to manipulate objects at an age appropriate level.	• may show splaying of fingers, immature grasping skills.	• provide child with opportunities to experience spatial relationship through motor mazes, outdoor play and indoor play.
	• may have difficulty manipulating objects (stacking, stringing, cutting, drawing).	• provide a variety of tactile and small motor activities (water and sand play, pegboards, puzzles, blocks, legos, etc.).
	• may exhibit tremors when stacking, stringing or drawing.	• observe child and note tremor occurrences and duration and how child compensates for tremors.

F. HOME-SCHOOL PARTNERSHIP

The home is recognized as an essential part of the curriculum. Research has indicated that early intervention programs are . . . [effective] . . . in producing long-term, positive results only when parents/caregivers are part of the program design. Interactions between teachers and parents/caregivers must be professional, sensitive and flexible. This relationship must be based on the expression of mutual concern and goals.

Parents of children at risk may themselves have past and/or present experiences which can compromise their ability to effectively parent their child. Factors which may include poverty, depression, a history of child abuse/neglect, family instability and violence, history of psychiatric problems, drug abuse, etc. are taken into consideration when staff is addressing the child's needs with the parent.

Children who reside in foster homes or are placed with extended family members are particularly vulnerable to the consequences of separation, loss and poor attachments. These children require ongoing support and coordinated case management plans with the goal of maximizing the child's success within the home and in the school. The emphasis on strengthening the positive interaction between caregiver and child increases the caregiver's awareness and understanding of the child's individual needs and assists in promoting feelings of confidence and competency within the caregiver. This empowerment of the caregiver will benefit the child far beyond his/her formal school program.

Having the knowledge of school/community resources and a genuine interest in the parent's well-being . . . [help caregivers form a strong] home-school partnership.

HEALTHY HOME ENVIRONMENT	AT-RISK ENVIRONMENT	TEACHING STRATEGIES
The child:	The child:	Teaching staff:
• has a mother who receives proper prenatal care.	• with prenatal exposure to drugs/alcohol may: - be premature - be small for gestational age - go through withdrawal - suffer damage to gastro-intestinal endocrine, respiratory genitourinary, cardiovascular and/or central nervous systems.	• recognize stressors in child's environment and attempt to minimize them.
• is provided consistent, responsive primary caregiver from birth.	• may have multiple home placements.	• approach child/family history with professionalism and respect for confidentiality.
• is provided predictable, safe, stable environment.	• may have multiple caregivers.	• identify family constellation and primary caregiver.
• has regular eating and sleeping patterns.	• may live with other young children who are at risk.	• develop relationship with the caregiver and open lines of communication with the caregiver.
• will have a mother/primary caregiver who sees herself as child's first teacher.	• may be abused and neglected.	• schedule ongoing visits to: - obtain a child's history (number of placements, medical history, family history, other agency involvement).
• is provided with established family rituals around daily living activities and special events.	• may receive inconsistent and intermittent nurturing.	

HEALTHY HOME ENVIRONMENT	AT-RISK ENVIRONMENT	TEACHING STRATEGIES
The child: • is provided appropriate developmental activities. • is encouraged to express feelings. • is encouraged to be self-sufficient and independent.	The child: • may have caregiver who is emotionally unavailable. • may have caregiver who is overwhelmed or untrained in dealing with the child's emotional needs. • may be exposed to chaotic, unpredictable and unstable environments.	Teaching staff: • schedule ongoing visits to: - identify current interventions used by caregiver. - discuss observations of child's behavior and progress. - observe and discuss caregiver/child relationship. - identify parental concerns and assess family needs. - develop individual family service plan. - facilitate referral to other agencies as services are needed. - encourage participation in parent education classes. • discuss and model the importance of predictability and organization: - by developing a transition plan with caregiver for entering school (books, toys, expected parent attendance). - by establishing regular patterns of communications with home (phone calls, classroom newsletter, informal notes, notebook back and forth). - by anticipating, discussing and integrating events at home and school (daily routine, special events). - by discussing implications of prenatal exposure to drugs/alcohol (short term and long-term effects). - by promoting an understanding of psychosocial risk factors (abuse, neglect, multiple caregivers/ placements).

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EDUCATIONAL NEEDS OF CHILDREN AT RISK[1]

Requisite for Success	Vulnerability for Failure
• The initiative to explore, to discover, and to learn	• Learning is an aggressive act. Disorganized children who are angry, passive, and/or fearful avoid new challenges, do not persist in difficult tasks, and do not seek to learn new things. All their energy is channeled toward coping with the internal and external stresses in their young lives. • Their fear, anger, and/or passivity needs to be addressed.
• The capacity to sit for periods of time, to focus, to concentrate, and to stay with a task to completion in a group setting	• Children at risk may have difficulty attending, be easily overstimulated and distracted by noise, movement, and too many children and things. • They need a protective environment in order to learn.
• The capacity to make and keep friends, to organize their own play, to do tasks on terms other than their own, and to size up situations before acting	• Children at risk may be impulsive, disorganized in play, and lack age-appropriate social skills. • They need to be *directly* taught and guided in many pro-social and learning-competence behaviors that other children learn incidentally.
• The value that significant adults are important sources of direction, guidance, comfort, information, and praise	• The young child who is raised in an at-risk environment may be poorly attached and lack basic trust. The child may appear insecure with low self-esteem. • Poorly attached children do not easily use adults to have their needs met. They do not respond to verbal guidance or verbal praise as one expects. They may constantly test the limits. They may be clingy, dependent, and unable to make decisions. • Self-mastery and self-dependence in learning and daily living skills need to be guided and encouraged. • Teacher-child relationship becomes a key component of intervention for poorly attached children.
• The coping mechanisms to handle the demands of classroom routines, large group activities, peer interactions and teacher expectations, and to . . . deal emotionally with the social, academic, and motor-performance demands that are a part of all children's lives	• Healthy attachments, family security, and an emotionally available parent provide the wherewithal for children to deal with the stresses of everyday life. Children at risk may have biological risks compounded if the surrogate or natural parent is too overwhelmed to meet their emotional needs. They tend to be hypersensitive and hyperreactive to their emotional and sensory environment and have a low tolerance for stress. • Children at risk may show regressive behaviors or catastrophic reactions to seemingly benign events. • They need help in developing coping mechanisms to adaptively handle stress.
• The developmental readiness to handle materials (pencils, balls, blocks); to listen to the teacher; to use language to express ideas, feelings, and solve problems; and to discriminate differences among social cues and visual forms	• Children at risk may evidence neurological dysfunction leading to learning vulnerabilities and/or disabilities in auditory processing, spatial-motor competence, problem-solving strategy, attention, and concentration. • They need special education strategies within the classroom and/or special education-related services.

[1] Reprinted with permission from Poulsen, p. 32.

STRATEGIES FOR HEALTHY DEVELOPMENT OF CHILDREN AT RISK[1]

Teachers who develop a strong relationship with the child at risk encourage that child's sense of self, self-mastery, and self-esteem when they:

- Provide for individualized adult-child personal interaction as part of each day's routine (touch, eye contact, hugs, cuddling, and/or talking).
- Model, encourage, recognize, acknowledge, and respond to the child's expressions of feelings, wants, and needs.
- Encourage and support self-dependence in self-help, play, and learning activities.
- Allow the child opportunity to "help" in the classroom as an important member of the group.
- Provide the children with toys of their own for the day.
- Model and encourage the re-creation of daily living experiences in representational play.
- Allow the child to lead in adult/child play on a regular basis.
- Provide for and encourage decision making.
- Support the child on difficult tasks.
- Allow the use of transitional objects.
- Develop individualized "hello" and "good-bye" rituals between self and child.
- Encourage and praise all attempts at developmental mastery.

Teachers create a protective responsive environment that helps the child at risk learn to organize and regulate their behavior when they:

- Work with a consistent team of classroom personnel.
- Establish classroom routines and rituals to allow the child to anticipate events.
- Provide and review daily "pictorial reminders" of class routines on a daily basis.
- Routinely alert the children that an activity will soon be over.
- Prepare the children for new changes in daily routines or classroom personnel.
- Protect the children from the overstimulation of materials, people, movement, light, and noise.
- Provide the child at risk with explicit expectations and recognition of positive behaviors.
- Set consistent limits on harmful behavior.
- Match the level of behavioral expectations with the level of the child's behavioral maturity.
- Help the child recover from stressful situations.
- Build relaxation in as part of the program.
- Provide the child at risk with a self-selected plan of respite when the child is feeling overwhelmed.
- Intervene before problems escalate to out-of-control behavior.

Teachers facilitate adaptive functioning in the child at risk when they directly teach those tasks that nonrisk children learn incidentally. Teachers help the child at risk learn to compensate for disorganized behaviors when they:

- Verbally/nonverbally guide behavior in close proximity with eye contact and/or touch.
- Model, rehearse, and guide positive peer interactions (turn-taking, prosocial behavior).
- Model, rehearse, and guide peer conflict resolution.
- Help the child at risk appreciate the "cause and effect" of his/her behavior.
- Model, rehearse, and guide play activities.
- Allow the child at risk to practice developmental tasks with tolerance for messiness and dawdling.
- Help the child at risk focus and attend to all parameters of developmental tasks.
- Provide verbal and/or nonverbal cues for spatial/motor and problem solving tasks.
- Encourage the independent use of alternative problem solving/task mastery strategies in peer and solitary play.
- Provide and encourage language to help the child at risk learn to reflect upon a situation before acting (stop-think-act).

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[1] Reprinted with permission from Poulsen, p. 49.

CHECKLIST OF BEHAVIORAL INDICATORS FOR CHILDREN WITH OVERWHELMING STRESS
(Behaviors You May Observe)

- Demonstrate overactivity.
- Are easily frustrated.
- Cannot make decisions.
- Cannot focus on or complete a task.
- Do not follow directions.
- Throw tantrums.
- Cling to adults.
- Hit, push, or grab to solve peer problems.
- Avoid new challenges.
- Do not play with other children.
- Cry frequently.
- Have eating problems.

CHAPTER 3
CHARACTERISTICS OF AN EXEMPLARY CHILD DEVELOPMENT PROGRAM PROVIDING EDUCATION AND CARE TO CHILDREN AT RISK DUE TO PRENATAL SUBSTANCE EXPOSURE

Introduction

In order for staff members to provide an exemplary program for at-risk children, they must have an understanding of how young children learn. Those trained in child development and early childhood education who have experience working with young children are more likely to provide an exemplary classroom experience. Ongoing training in best practices keeps staff current with research and developmentally appropriate teaching strategies.

The quality of a program depends primarily upon the staff. A program may move from an exemplary to adequate status or vice versa because of changes in staff. It is helpful for educators to visit and observe various programs. The information below will assist an observer in determining the quality of a program.

What an Exemplary Program Looks Like

An exemplary program for preschool age children revolves around interactions and the learning environment—this is particularly important for the child at risk — interactions between staff and children, interactions between adults, interactions between staff and parents, and an environment rich in materials and opportunities.

Interactions Between Staff and Children

Child development programs that are identified as *quality* day care or preschool programs have staff that appreciate each child's uniqueness and treat children with respect and dignity. The adults in the program are sensitive to the individual patterns of growth, personality, ways of learning, and ethnic, cultural, and family background. When you walk in to an exemplary program, you see the staff talking with children, not at them. The interactions and exchanges include children in solving problems, expressing their feelings in an appropriate manner, using their verbal skills to have their needs met, and developing the ability to communicate with others in a socially constructive way.

Above all, the adults promote interactions that are designed to help each child feel good about himself/herself and have positive feelings toward learning. Strategies used to discipline children are designed to help children learn self-control. These strategies would include using redirection, encouraging appropriate behaviors, modeling what is expected, and setting clear, reasonable limits. Before using a particular strategy, the adult must ask, "What do I want the child to learn from this situation?"

Child Care and Preschool Staff Interactions

The staff in an exemplary program serving preschool age children are knowledgeable in human growth and development, have cultural sensitivity, and have formal training in early childhood education. Well-trained staff are more likely to understand the importance of a responsive, loving relationship between the adult providing care and the child. This relationship is an important determinant of social and emotional development for the child. It is also important for teachers/child care providers to set time aside for ongoing communication among themselves about the curriculum, children, parents, and program. The ability to communicate in an open, honest manner and to act upon the discussions to enhance the program's effectiveness is an important indicator of quality.

Parent and Staff Interactions

A highly effective program includes the adult who cares for the child after preschool/child care. This adult is usually the parent, but may be a foster parent, relative, or friend. In the following paragraphs, a reference to "parent" means the individual who is the primary caregiver for the child.

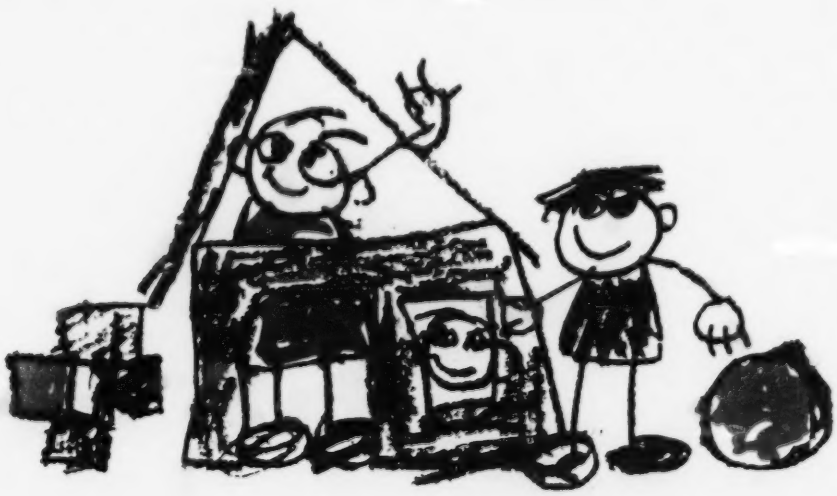
Including the parent as a partner in the care and education of the child will benefit everyone. In a quality program the staff greets the parent as well as the child and communicates daily with the parent about all the wonderful things the child has learned or done during the day. The parent feels part of the child's preschool or child care day. There are times when the adults are concerned about a child. When there is a concern that must be addressed to the parent, the teacher/child care provider must be sensitive to the parent and how the parent may react. Particular care must be taken if the staff are concerned that the parent may "take it out" on the child. The staff in an exemplary program develops a caring relationship with the parent before meeting with the parent to discuss sensitive issues.

Child Interactions

Interactions between children can be another indicator when determining the quality of a program. An exemplary program provides many opportunities for children to interact. Most preschool age children engage primarily in **parallel** play (playing along side another child) or **associative** play (playing along side and talking with another child). There will be times when a child wants to play alone (**solitary** play) or play with other children (**cooperative** play) to accomplish a common goal. As children play, there should be a richness in the communication and play that includes cooperating with one another, helping, negotiating, solving problems, laughing, and looking like they are having fun.

The Learning Environment

An exemplary environment provides many opportunities for children to explore, create, practice, play, interact, and experiment—depending on their ability to do so. Books are on shelves, and the program is rich with other materials that are relevant to preschool-age children and reflect their ethnic and cultural diversity. A variety of materials are available for children; however, materials are limited at any given time to avoid overstimulation. Learning activities are concrete and relate to the group's life experiences. Children spend most of their time in small, informal groups, and the activities are child-selected whenever possible. Materials, supplies, equipment, and pictures are placed at the child's level. The teacher sets up the activities and the room arrangement so that children will make good choices. Play areas are clearly defined and choices are presented according to the child's ability to make decisions. The outdoor space is just as important as the indoor space. Children are provided with an outdoor program that builds small and large muscle coordination, encourages turn-taking and sharing, offers opportunities for



social interactions and problem solving, and is fun. If you walk into an exemplary program, you will see children busy, moving about in a positive way, and engaged in an activity or in play. Most of the interactions will be positive and constructive.

The strongest environmental influence in the child care or preschool program is the staff. Using the guidelines in *Developmentally Appropriate Practice In Early Childhood Programs Serving Children From Birth Through Age 8*, pages 47–61 (see Selected References), and the information provided in this section, early childhood educators can evaluate programs for exemplary status and replicate what they observe in their own practices.

Taking Care of Yourself

Providing a nurturing, safe learning environment for children requires a great deal emotionally, intellectually, and physically. Individuals working with children must always be "available" during the hours they are responsible for the care and education of children, particularly when working with children at risk. There is minimal time during the day to reflect on how a situation was handled or to discuss with other staff a situation or a particular child. However, building this time into a day is essential to a quality experience for children and is important to the well-being of staff. A daily communication period offers staff the opportunity to discuss situations and different strategies and provides a time when staff can support one another. Setting aside 15 minutes at the end of the day or at nap time will increase team work and reduce problems that stem from poor communication.

Staff working on a daily basis with young children at risk are particularly vulnerable to fatigue. To counteract fatigue, staff must learn to take care of themselves. A self-care regimen could include a daily exercise program, short planned excursions, club or other ongoing activities, or gatherings with friends on a weekly basis. Whatever the activity, it should be ongoing and offer opportunities to talk about something besides children. To have healthy relationships with children and families, staff working with children and their families must practice self-care techniques that keep energies high and attitudes positive.

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CHECKLIST FOR INDICATORS OF QUALITY
(Items You May Want to Include in Your Program)

- Staff is trained in child development and ethnic and cultural sensitivity.
- Ongoing staff training is part of the program.
- Staff members model behaviors they want from children.
- Staff members get down to the child's eye level.
- Children and staff are treated with respect.
- Records of ongoing child observation are available.
- A variety of information—including anecdotal records, skill assessment, and parent reports—is used in assessing the children.
- Parents are encouraged to participate in the program.
- Staff members use redirection, encouragement, modeling, and reinforcement to manage the children's behavior and set realistic, clear limits.
- Adults are responsive to the needs of children.
- Staff meetings are held regularly.
- Staff members communicate daily about children, curriculum, and planning.
- Staff members communicate both formally and informally with parents and have reliable strategies for overcoming language barriers.
- Many opportunities are provided for play.
- Pictures in the room are placed at the children's eye level.
- Furnishings are the appropriate size for the children.
- A broad range of materials, supplies, and equipment is available which includes books, paints, blocks, props, and manipulatives.
- The curriculum is well planned and ethnically and culturally sensitive.
- Learning activities are concrete and relate to the group's life experiences.
- Children are encouraged and assisted in solving their own problems.
- Materials, supplies, and equipment are safe—free from jagged edges and broken parts.
- The room is inviting and clean.
- Children are encouraged to verbalize their feelings, wants, and needs.

CHAPTER 4
DEALING WITH CHEMICAL DEPENDENCY AND THE FAMILY: PRACTICAL GUIDELINES FOR TEACHERS AND CHILD CARE WORKERS

Introduction

The purpose of this section of the guide is threefold: to provide a general overview of the disease of chemical dependency, to explain the reasons addicted parents may not seek treatment, and to offer practical suggestions for working with the parents, relatives, and/or foster parents of children at risk due to prenatal substance exposure. This section explores in more detail key points about the chemically dependent family. (These points are presented in the *Just Kids* videotape, available from the California Department of Education. See the end of this publication for ordering information.)

The Disease of Chemical Dependency

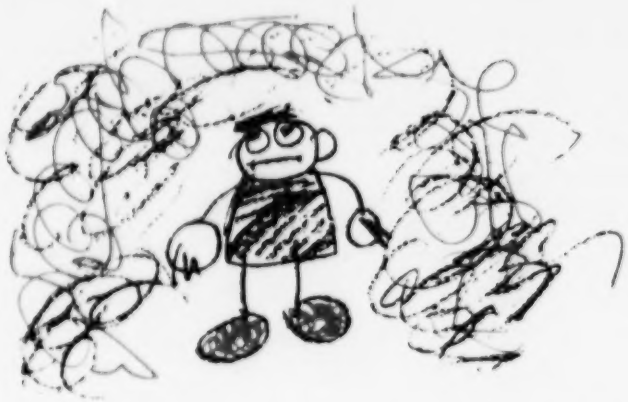
Chemical dependency is a condition in which a person is **unable** to stop ingesting a chemical even though it is causing harm to him or her or to someone else. There may be a point in a person's life where the need for the chemical is so strong that it often supersedes his or her own moral and personal convictions. The chemicals most often used are alcohol, nicotine, marijuana, cocaine, amphetamines, heroin, LSD, pain killers, and prescription medications.

It is often difficult for a person who has never experienced a chemical dependency to understand the concept of an addiction. However, people who have gone on a diet, lost weight, "broken" the diet, and returned to their old eating patterns may have some inkling of how difficult it is for the addict to stop a well-established behavior. Dieters could imagine that while dieting, they turned down a chocolate donut and didn't get the satisfaction of something that they liked and made them feel good (if only for a moment). If they also began to experience extreme physical and emotional discomfort because of not having the donut, they are even closer to understanding the pull of an addiction. As with most dieters, most addicts and alcoholics have tried unsuccessfully to change their abusing/using behaviors. These unsuccessful efforts are especially common among pregnant addicts who try to stop or decrease their use throughout their pregnancy.

Chemical dependency affects families of all economic, ethnic, and cultural backgrounds, although some ethnic groups display unique patterns of drug use or specific drug tendencies. Because this disease can be so devastating, why do people become addicted to drugs and alcohol in the first place? This is not a question that can be fully answered in a few paragraphs, but some general reasons follow:

First, chemical dependency is a **multi-generational family disease**; that is, the drugs and alcohol affect everyone in the family, not just the user. Also, it is a disease handed down from one generation to the next. During the childhoods of most addicts and alcoholics, parents or grandparents actively abused or excessively used drugs or alcohol. The children were taught, although not intentionally, to drink or take a drug to help deal with feelings and life's stresses. The family system and relationships between family members often acted to keep the addict/alcoholic dependent on substances.

. . . **no one** thinks he or she will become addicted.



Second, it is the current belief in the substance abuse field that there is a strong **biological or genetic component** to this disease. Most of the research in this respect has been done with alcoholics. There has been active speculation that within the next 20 years the gene for alcoholism will be isolated. Whether or not the theory of predisposition for chemical dependency is proven, it is clear that addiction is a biological process as well as a psychological one. Anyone who abuses drugs or alcohol over a prolonged period of time will become addicted, regardless of family history.

Third, most alcoholics and addicts grew up in a **dysfunctional family system**. Thus, as children, they frequently did not receive enough of the attention and limit setting that was needed to develop a strong feeling of self-worth. Emotional, physical, and sexual abuse are also often manifest in dysfunctional families. Therefore, the parent can have not only an addiction, but an underlying mental health disorder as well. Further, if the parent were a member of an economic, ethnic, or cultural minority, he or she may have been openly or covertly discriminated against by society as a whole. Such family-related indicators, plus economic instability and a childhood spent amid chaos, violence, and danger can add to or create the feelings of low self-esteem and hopelessness needed to fuel an addiction.

Fourth, and perhaps most importantly, addiction can begin with the first drink or first drug, but **no one** thinks he or she will become addicted. **The majority of addicts and alcoholics began using in their teen years**. Some teenagers may feel they are omnipotent and all the "bad" things associated with drugs and alcohol will happen to someone else — not them.

Why Some Addicted Parents Do Not Seek Help

With the general overview of the disease of chemical dependency presented above, it is easier to understand why parents do not always seek treatment immediately. Usually parents repeatedly try on their own to stop substance abuse before they seek help. Often family, friends, and medical providers unwittingly discourage parents from getting help by enabling or rescuing them, rather than allowing them to experience the consequences of their behaviors.

Women also have the added fear that if they seek help, their children will be removed from them. Until very recently, treatment facilities have not been sensitive to mothers' needs and have prevented women from getting treatment while continuing with their parenting responsibilities. In addition, clinical anecdotes, as well as recent statistics collected by the Options for Recovery Perinatal Projects in California, indicate 80 percent or more of women in chemical dependency programs have been sexually abused in their childhood and getting help means dealing with this very painful issue.

Even with all these factors working against them, parents do get help and get better. The road to recovery is not a straight line and parents may return to abusing drugs and alcohol for awhile before maintaining long periods of sobriety. For the parent to sustain recovery, a change in family relationships is as essential as stopping the drug and alcohol use. To effect such a change, the whole family needs to seek help, not just the abusing/using parent. The next part of this section will focus on what the child care provider can do to help the parents and children affected by chemical dependency.

PRACTICAL SUGGESTIONS FOR WORKING WITH PARENTS OF CHILDREN AT RISK DUE TO PRENATAL SUBSTANCE EXPOSURE

1. Discuss feelings and beliefs about substance-abusing parents with colleagues. It is important to examine and understand your own feelings on an ongoing basis so you do not unintentionally judge, overreact, or underreact to the parents.

2. Develop a strong alliance with the parent and an understanding of the family history to best serve the child. If the parent feels safe with you, that feeling will be relayed to the child and make the transition from home to your program much easier. Because some at-risk children have a difficult time with transitions, the parents' comfort level can be especially important. Many people with chemical dependency problems have a difficult time trusting others. You will be seen as an authority figure and thus someone to fear. The following practices can help build trust with the parent:

   a. Always acknowledge the parent first and the child second. This practice tells the parent you are glad to see him or her, not just the child.

   b. Interview the parent before the child comes into the program, whenever possible. (See the list of what to include in this interview on page 39.)

   c. Whenever possible, set up the interview at the parent's convenience rather than the program's convenience.

   d. Have the appointments in the late morning or early afternoon. If the parents are still substance-abusing or are in early recovery, early mornings and late afternoons are often difficult times of the da for them.

   e. Reschedule missed appointments without being punitive. If parents do not make the first appointment, do not assume they did not **want** to come; they may have been scared or under the influence.

   f. Always follow through with what you tell parents you will do, no matter how minor the task.

   g. If you need to talk with **anyone** other than parents about a child, discuss that need with the parents. Always get their permission, even for fun things like "Toys for Tots."

   h. Do not send home notes with the children about "misbehaviors." Remember that their parents were often labeled as the "bad" kids in school; a note sent home may mean more to them than it does to you.

   i. On a daily basis, try to tell the parent about a positive trait or behavior you observed that day with the child. Such a practice will make it easier to discuss a difficult behavior in the future.

3. Do support parents when they ask for help with their alcohol or drug problem. The best time to make a referral is when parents ask for one. The occasion may occur after they have grown to trust you or are in a crisis and feel you can help them. Have a list of resources available.

4. Do not engage in codependent or rescuing behaviors that only prolong parents' denial and prevent them from needing to seek help. Specifically:

   a. Do not loan parents money under any circumstances.

(continued on next page)

PRACTICAL SUGGESTIONS FOR WORKING WITH PARENTS OF CHILDREN AT RISK DUE TO PRENATAL SUBSTANCE EXPOSURE

(continued)

b. Do not hold an interview if the parent is under the influence. Tell him or her you will call later to reschedule.

c. If the parent is under the influence and is driving a car, confront the parent and, if he or she continues with the behavior, notify the police. For example: The parent comes to pick up the children and is obviously intoxicated. Politely but firmly tell the parent he or she appears to be intoxicated and is in no condition to drive. Offer the use of the phone to call someone to pick up parent and child. If the parent refuses, state that the program's policy is to call the police if an intoxicated person gets in the car with children because it is a danger to them all. Do **not** try to hold on to the children.

d. If the children arrive dirty and without proper clothes for the weather, tell the parents in a factual, nonjudgmental manner your program's expectations for the children's appearance. Do **not** simply clean the children and loan clothing to them.

e. Give the parents some extra time and encouragement, but be careful not to become their "counselor." For example: Parents may tell you that you are the only one they can really trust or talk to. Thank them for their trust in you, but reinforce that, since they learned to trust you, they have the ability to trust others, especially a counselor.

f. Do not give out your home telephone number. Instead, give out a referral or crisis line number to reach trained people who can also provide support.

g. If you are feeling overwhelmed or "burned out" with a family, talk with a colleague about your feelings. You may have fallen into some codependent behaviors.

5. Identify and coordinate with the other agencies serving the family. This practice is essential if the child has special needs and a variety of providers are working with the child. Remember, the parent is the most crucial and consistent care provider for the child and must be a key member in the planning for the child.

6. Get information from all staff members about the child, but designate one member the primary contact for interagency coordination and communication with the parent.

7. If Child Protective Services (CPS) is involved with the child and parent, ask the parent to allow you to talk with the worker. The focus of the interaction with CPS should be to assist the parent in learning more about the child's developmental needs or increasing parenting skills. If participation in your program is a CPS mandate, it is important to have a joint meeting with the CPS worker and the parent to clarify expectations and what information or reports will be given to CPS.

8. Make an effort to point out all the minor as well as major positive changes you see in parents' interaction with the children.

9. Be consistent with your caring and support for the parents, whether they act on your referrals or not. Remember, these parents want what **all** parents want for their children. Sometimes their disease makes it hard to see this. Some days the best they can do for their children is to get them to your program where they know they will receive good care.

INITIAL INTERVIEW IDEAS

1. Begin the interview by thanking the parent for coming and letting her/him know you interview **all** the parents.

2. Start with questions that show an interest in the parent rather than the child. For example: "We believe that the parents are as important to our center as the children. Over the next few weeks we'll get to know your son better. I'm wondering whether we could take a little time today to get to know each other."

3. When asking questions about the child, reinforce that the parent knows the child best and you need her/his help to better work with the child.

4. Tell parents that they are required to report all bumps and bruises when the child walks in for the day. For example: "Please advise us of all his scrapes so we know if he gets a new one at school and can in turn tell you about it."

5. Be very specific and detailed about your policy on reporting child abuse to the authorities. Reinforce that the policy is the same for all parents. For example: "We call CPS for the following reasons: if there is a severe burn or bruise; if the child tells us someone hurt him or her; if a child is very dirty or wears the same clothes a few days in a row; or if the child tells us repeatedly he or she has not had any breakfast."

   If you need to make a CPS report, it is strongly recommended that you inform the parents of your need to do so unless telling them would put the child in danger.

6. Tell parents that you will have regular meetings with them to talk about what the children are doing and how you can work together to best meet their children's needs. Let them know that a meeting does not mean a child has done something wrong.

7. Keep the interview to between 30 and 45 minutes. Start and end the interview at the time you told the parent you would.

8. If possible, schedule two or three meetings in the first four to six weeks to gather more information. Tell the parent you plan to do so. The first interview should be designed to begin to develop a trusting, working relationship with the parent, rather than to obtain detailed information about family and substance-abuse histories.

9. Give the parent your "Child History Form" to fill out **after** the initial interview. You are more likely to get it completed and returned to you if the parent knows who you are and why you need the information.

10. The best results in completing the "Child History Form" occur when the child care provider asks the questions in an interview. If your program's policy allows such a practice, get only the most necessary information during the initial interview. Save the remaining questions for subsequent interviews.

11. Make a general statement near the end of the interview about the referral resources you have available. For example: "As you know, raising children can be difficult at times. It is not uncommon for parents to have marital, family, or substance-abuse problems that may affect the children. If such problems should occur, feel free to let us know and we can give suggestions as to how to help the children deal with the problems better. We keep a list of clinics and programs that our parents have found to be helpful to them in the past. We would be happy to share the list with you if you ever need it."

12. Give parents a handout of ideas to help the children prepare for your program. It should include the following points:
    - Get the child up early at the same time every school day.
    - Prepare a balanced meal for breakfast, including fruits and complex carbohydrates. Make sure the child eats it.
    - Wash the child's face, brush the teeth, comb the hair.
    - Pack the child's school things and have them ready by the time the child leaves for school.
    - If the child has a favorite toy, let the child bring it to school where he or she can get it when it is needed. (This practice is particularly important for those children who have had multiple placements.)
    - Pack a lunch for the child if the child care program does not provide one. (Provide to the parent a list of foods that are nutritious and do not contain high levels of sugar.)

PRACTICAL SUGGESTIONS FOR WORKING WITH FOSTER PARENTS/RELATIVE CAREGIVERS

1. Have an initial interview with the caregiver before the child enters the program.

2. Reinforce the important role the caregiver provides to the child and to your program.

3. Ask the caregiver who has legal custody of the child, even if the child is in foster care. It is possible for the child to be in voluntary foster care with the parents retaining all of their parental rights.

4. Ask about the caregiver's relationship to the parent. It is important to be especially sensitive here. The caregiver may have a good relationship with the parent or a very difficult one. If the caregiver begins to express anger or a judgmental attitude toward the parent, it is important to acknowledge the feelings but not agree with the beliefs. For example: "My sister is such a bad parent. She only cares about herself. She left her three-year-old daughter alone to go look for drugs. I don't think she should ever get her children back. Do you?" "I understand how upset you must be with your sister. It is very hard when a parent's behaviors are harmful to a child. The disease of addiction can cause good people to do harmful things to themselves and those they love at times."

5. Ask the caregiver how long the child has been in his or her home and how long the child will remain there. This information can help with planning for transitions with the child.

6. Ask the caregiver how the parent is to be included in activities involving the child.

7. Ask who is to be notified in an emergency.

8. Find out the name, phone number, and best time to get in touch with the CPS worker assigned to the child. Advise the caregiver that you intend to contact the CPS worker and that it is part of a procedure you follow with all children to work together as a team.

9. Have the team member who will be responsible for coordinating care of the child contact the CPS worker and ask:

   a. Who is the legal guardian?

   b. In what activities can the parent be included? The response may be significantly different from the caregiver's understanding.

   c. Who is to be notified in case of emergency? The answer to this question also may be different from what the caregiver believes.

   d. What are the general concerns about the child?

   e. What type of information will CPS want from you regarding the child?

10. Invite the CPS worker to your program to become better acquainted with you and the services you provide.

11. If the information you receive from the caregiver and the CPS worker are significantly different, especially in regard to the parent's involvement, let them both know that you are confused regarding some issues with the child, and request a meeting to include all three of you. If a meeting cannot be scheduled, the CPS worker's instructions should be followed as closely as possible, and the caregiver needs to be informed and included whenever possible.

12. If the parent is to be included in your program and the caregiver's relationship to the parent is strained, do not use the child as a means to improve the relationship. For example, have the parent and caregiver present at different times during the day rather than schedule simultaneous activities with them.

(continued on next page)

PRACTICAL SUGGESTIONS FOR WORKING WITH FOSTER PARENTS/RELATIVE CAREGIVERS
(continued)

13. When a relative rather than a foster parent is the primary caregiver, be sure to provide support but do not **blame** anyone for the current situation. Feelings of guilt or responsibility for the child may be very strong, especially if the relative is a grandparent or if the relative has used drugs or alcohol.

14. Provide a list of referrals to the relative if assistance is requested.

15. Provide a checklist of things the child should do every morning before coming to your program. (This list is similar to the one used for parents.) It should include:
    - Get the child up at the same time every school day.
    - Feed the child a balanced breakfast with fruits and complex carbohydrates.
    - Get the child to practice washing his or her face, brushing teeth, and combing hair daily.
    - Pack all the child's school things by the time the child is ready to leave.
    - Allow the child to bring a favorite toy to the program, especially if it gives some reassurance to the child.
    - Give the child reassurance because children who have had a number of different caregivers often may be fearful or reluctant to leave home. Special preparation may be necessary to ease the transition to the new surroundings.

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CHAPTER 5
ASSESSMENT

Introduction

The assessment component of this guide is intended to help the preschool teacher identify and refer children who demonstrate difficulty in the mastery of age-appropriate developmental tasks. A set of guidelines for assessing children in the domains of cognitive, language, social-emotional, and motor development can be useful to teachers in monitoring developmental progress. Assessment is important because research has demonstrated that early identification and intervention are most effective when implemented in the preschool years. Early childhood experiences in a preschool environment can have a lasting impact on children's self-esteem and confidence.

It is our hope that all children entering a preschool learning environment will have access to and benefit from an evaluative process which takes into consideration the whole child. All children must be evaluated on individual abilities and understood within their particular familial context. A comprehensive assessment of children in preschool settings should focus on aiding children in the acquisition of age-appropriate skills. The discussion and guidelines which follow are a part of the best child care practices indicated for all children, not only those who were prenatally substance-exposed.

Definition of Assessment

Assessment is a process by which information is gathered about a child to develop a profile of the child's strengths and weaknesses in the domains of cognitive, language, social-emotional, and motor functioning. It is a process that requires communication between caregivers and professionals working together to maximize a child's potential capabilities.

Process of Assessment

A comprehensive assessment must take into account the child's familial context, socio-economic status, ethnic group, culture, developmental history, relationship functioning, and observable behaviors. It is a process which requires that caregivers be involved from the beginning. The process should be initiated by the teacher through an intake or interview with the caregivers. Teachers provide informal and formal data based on observations of play and overall behavior within the preschool environment. A developmental screening will confirm how a child has mastered specific age-appropriate tasks. All of this information together will provide direction to teachers and caregivers on how best to help a child succeed in the learning environment. Evaluators must be aware of any subjective biases (i.e., stereotypes) they may bring into the assessment and interview process.

Standardized and Nonstandardized Methods of Evaluation

Standardization implies uniformity of procedure in administering and scoring a test. An important aspect of standardization is the establishment of norms. A norm describes the test performance of specified groups in the standardization sample of a test. What is important for teachers or clinicians who use standardized tests is to evaluate the date the norms were established, the size of the norm group (generally, the larger the number of subjects, the more stable the norms), and to consider how relevant the norms are to the evaluation of the child. If fair interpretation of a child's test

performance is the goal, the norm group against which the child's performance is evaluated must be known. For some purposes national norms may be most appropriate; for other purposes, the norms of a particular segment of the population may be most relevant.

Interviews, observations, checklists, and rating scales offer important information about children in naturalistic settings and are valuable to the overall evaluation process. They can be used in combination with the child's performance on standardized screening instruments for identifying potential problems. They serve as valuable methods for developing curriculum and teaching activities and evaluating children's progress.

To develop accurate developmental profiles of children in preschool environments, standardized and other information-gathering approaches must be utilized to provide an authentic assessment of the child's capabilities. Assessments of this type require cooperation and coordination on the part of teachers and caregivers.

The Difference Between Developmental Screening and Diagnostic Assessment

The assessment process in the preschool environment is comprehensive and is completed over a period of time. It utilizes both informal and formal methods of data collection. At times the teacher or caregiver uses a brief procedure to identify children in need of a diagnostic assessment. One such procedure is a *screening*, defined by Meisels and Provence as follows:

> A brief assessment procedure used to identify children who should receive more intensive diagnosis and assessment. Screening is designed to help children who are at risk for health and developmental problems, handicapping conditions and/or school failure to receive ameliorative intervention services as early as possible.[1]

Developmental screening should never be used as the basis for labeling or diagnosis of a child. Developmental screening serves as the basis for identifying children who may have a learning problem or developmental delay. Developmental screening can be the basis for intervention and an ongoing plan of amelioration.

Teachers need to demonstrate that, over a period of time and with intensive intervention, a child has been unable to progress in obtaining age-appropriate educational objectives. The developmental screening is one piece of information that documents a child's areas of strength and weakness. It provides the teacher with a plan for intervention and a yardstick by which to review the mastery of specific skills. If a child fails to make progress after a reasonable period of developmentally appropriate intervention, a referral should be made for a diagnostic assessment. A child may fail to qualify for a more extensive diagnostic assessment if only one screening source is used. Screening of the child's performance over time and in different contexts should be used to identify children who may have learning problems. For children with several risk factors—environmental, medical, and familial—a developmental screening process is the most important step for planning intervention approaches in the classroom, for determining the effects of this intervention, and for determining the need for making a referral for a diagnostic assessment.

A diagnostic *assessment* consists of a battery of standardized tests, interviews, and clinical procedures used by physicians, psychologists, speech and language therapists, and other health professionals to determine if a child has a special need. Diagnostic assessments are performed by a transdisciplinary team of professionals who work together to identify the child's potential for learning, the nature of a child's problems, the possible causes for delays or deficiencies, and the most appropriate program of service. A comprehensive diagnostic assessment that includes information from the teacher and primary caregiver is necessary for determining whether a child has a learning problem or deficiency that requires special intervention programs.

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[1]Reprinted with permission from Samuel J. Meisels and Sally Provence, *Screening and assessment: guidelines for identifying young disabled and developmentally vulnerable children and their families*. Washington, D.C.: National Center for Clinical Infant Programs, 1989, p. 58.

Guidelines for Screening and Assessment[1]

1. Screening and assessment should be viewed as services — as part of the intervention process—not only as a means of identification and measurement.

2. Processes, procedures, and instruments intended for screening and assessment should only be used for specified purposes.

3. Multiple sources of information should be included in screening and assessment.

4. Developmental screening should take place on a recurrent or periodic basis. It is inappropriate to screen young children only once during their early years. Similarly, provisions should be made for reevaluation or reassessment after services have been initiated.

5. Developmental screening should be viewed as only one path to more in-depth assessment. Failure to qualify for services based on a single source of screening information should not become a barrier to further evaluation for intervention services if other risk factors (e.g., environmental, medical, familial) are present.

6. Screening and assessment procedures should be reliable and valid.

7. Family members should be an integral part of the screening and assessment process. Information provided by family members is critically important for determining whether or not to initiate more in-depth assessment and for designing appropriate intervention strategies. Parents should be accorded complete informed consent at all stages of the screening and assessment process.

8. During screening or assessment of developmental strengths and problems, the more relevant and familiar the tasks and setting are to the child and the child's family, the more likely it is that the results will be valid.

9. All tests, procedures, and processes intended for screening or assessment must be culturally sensitive.

10. Extensive and comprehensive training is needed by those who screen and assess very young children.

Preschool Assessment Protocol

The preschool assessment protocol consists of: (1) parent interview and developmental history, (2) administration of developmental screening tests and instruments, (3) play observation, and (4) behavioral observations.

A reference to "parent" in this section includes anyone who cares for the child in his or her home setting. This person may be a foster parent, a biological parent, a relative, or a family friend.

Parent Interview and Developmental History

The parent interview is a critical aspect of the assessment process. It is important because the parent is asked to participate as a partner in evaluating the child's strengths and weaknesses. Teachers and child care providers need to treat parents with respect and consideration because the parent has the most information about the child.

The teacher/child care provider should explain what the concerns are about the child in the educational environment, and the parent needs to understand the assessment process step by step. Framing the relationship between the teacher/child care provider and parent as a partnership will help the parent to feel included and valuable during the assessment process.

Parents can provide information about the past and the present. They can provide insight into behaviors that occur in the home environment. However, there are times when parents may not be good reporters of behavior. These situations are generally associated with the individual's lack of historical information, as in the case of a foster parent or a relative who recently gained custody or guardianship of a child. A biological parent who is involved in substance abuse may also be an unreliable reporter because he or she is not spending time with the child. No matter what the situation, interviewing the parent will provide an important source of data about the family context and the child's role within the family.

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[1]Reprinted with permission from Meisels and Provence, pp. 23–26. (Also reprinted for duplicating purposes on p. 52 of this publication.)

The primary focus of the interview with the parent will be on gathering developmental data consisting of the following:

1. Birth Information
    a. Was the child born full term or prematurely?
    b. Was the delivery normal or complicated?
    c. Were there any postdelivery problems?
    d. Did the infant go home or remain in the hospital?
    e. Did the parent smoke cigarettes, drink alcohol, or use drugs?
2. Developmental Milestones
    a. When did the infant smile, roll over, sit, crawl, walk, begin eating solids, and start talking?
    b. Are there any health issues or concerns?
    c. Who is the child's pediatrician?
    d. Have there been any changes in caregiving?
3. Ongoing Assessment
    a. What kinds of concerns do the parents have? Why?
    b. What do they see as the child's strengths/weaknesses?
    c. What kinds of observations can they share about the child?

Developmental Screening

A good developmental screening will be reliable and valid with norms based on a diverse population. It will focus on age-appropriate skills for preschool children. It will sample a range of abilities such as visual-motor skills, visual sequential memory, language and cognition, verbal expression and reasoning, auditory memory, gross motor skills, and social skills. A developmental screening will not give an intelligence quotient, but instead will provide a developmental age or give information about the child's level of competence as being within the norm, questionable, or of concern.

A teacher can use the information gathered about the child's cognitive and visual-motor functioning to develop and implement an educational plan. The child should be reassessed at appropriate intervals and, if the results remain questionable or of concern, the child should be referred for a diagnostic assessment. Results should be shared with parents and intervention strategies should be explained so that they can be utilized by parents in the home environment.

Selecting a Developmental Screening Instrument

For early childhood educators in California, several decisions were made in the courts, at the state government level, and in local school districts that affect the selection of a developmental screening test.

Court orders and the California Department of Education's interpretation and application of these directives resulted in the prohibition of intelligence tests and other standardized instruments found to be racially and culturally biased for assessing African-American children. Some educational agencies have extended this practice to other racial and ethnic minority groups.

The California Department of Education's Special Education Division is working toward the elimination of the diagnostic model for special education assessment and, in its place, the use of performance-based, portfolio, and curriculum-based assessments. This direction is consistent with the California Learning Assessment System (CLAS) which is including these alternative models in addition to standardized achievement tests.

Early childhood educators must also adhere to the intent and decisions of the court and to the practices of the special education departments of their local educational agencies (LEAs). Educators should obtain from their LEA a list of the screening instruments which cannot be used for assessing the development of African-American children and possibly other racial and ethnic groups, and a list of alternative instruments and procedures for this purpose.

Whether selecting a screening test from the general publications or from a specified list of the LEA, early childhood teachers should determine that the test has respectful measures of validity and reliability. Validity refers to how accurately

the screening test measures what it was designed to measure. The items on a developmental screening instrument should be behaviors that are accurate representations of the areas of language, cognition, speech, affect, perception, and gross and fine motor development. If the screening instrument has good validity, there will be a higher probability of correctly identifying children at risk in terms of developmental delay and those who are not at risk. A screening instrument should also be reliable, which means that if the test were administered several times to the same child, results would be similar. Reliability also means that if this testing were done over time, and there are differences in results from one session to another, these differences can be attributed to real changes in the child's development. The measures of reliability and validity are reported in the examiner's manual and teachers and parents should feel confident with this information.

If the criteria for validity and reliability are met, teachers must then determine that the instrument is fair to the children in their groups. If the teacher is using an instrument from a list of tests that have been approved by the local educational agency as not racially or ethnically biased, the issue of fairness may be partially addressed. However, it remains important to review any instrument to determine that the language, pictures, or other materials used in the directions or individual items are familiar enough to the children to give them a fair opportunity to understand the directions and perform the items.

In selecting a screening instrument, it is important that the test or rating scale not discriminate against any of the children in the program. The children who are screened should be very similar in characteristics to the children who make up the norm sample. The information about the norm sample is contained in the examiner's manual and should be read carefully to know whether the children will have a fair opportunity to be accurately screened as not at risk or at risk for developmental delay. If the characteristics of the screened children are similar to those of the norm sample (or a subgroup that makes up the norm sample), the performance of the screened children on the screening instrument can be compared with the reported scores from the norm sample or subgroup.

There should be greater similarity for some characteristics. The socioeconomic status of parents (occupation and levels of education) for the norm sample and the sample's ethnicity and primary language should be very similar to the screened group. The characteristic of geographic region may not have to be as similar. For example, more of the screened children may live in a large city than the percentage of children in the norm sample. If the difference is great, then you have to decide whether this characteristic eliminates the use of that screening instrument. Because norms will be established for different age groups of children, this variable is of no concern.

When comparing the scores of the screened children with the scores given in the norm tables for the different age groups to decide what children may be at risk and should be referred for a diagnostic assessment and/or receive special programming in your classroom, certain criteria may apply. The early childhood special education unit of your local school district or SELPA (Special Education Local Plan Area) should be consulted to determine what guidelines may apply for referring a child for a special education assessment. Whenever possible, the program should attempt to develop its own norms and standards of typical and desirable behaviors through systematically analyzing the results of the screening test. This practice assures consideration of any special characteristics of the screened children and of the program that may influence performance. It also provides very helpful information for evaluating and developing curriculum and teaching approaches.

Authentic Assessment

Early childhood teachers serve as leaders for the current statewide movement toward "authentic" assessment. Developmentally-based assessments and observations of children's behaviors in a number of different contexts and over time have been long-standing practices in the field. What teachers and parents recognize is that young children are similar to one another in how they express their growth and development, and, at the same time, they are different from one another. To understand and appreciate this mixture for any one child and to know when some pattern of a child's behavior is not "fitting" with expectations, teachers and parents must use their knowledge and skills, multiple assessment approaches, and a valid and reliable screening instrument.

Play Observation

Play behavior can provide a wealth of information about the child's symbolic thought processes. Age-appropriate preschool play will provide insight into the child's imaginative world with mastery themes dominating the quality of play.

Children's play follows a set developmental patterns that emerges during the second half of the first year (Piaget, 1962; McCune-Nicolich, 1981; Fein, 1981; Belsky and Most, 1981). The quality of a child's play progresses from simple object manipulation to complex object/toy manipulation. Simple play is characterized by reaching, holding, and attending to an object. Complex object manipulation includes exploring, poking, and turning objects in space. The child seeks information about the object in order to utilize it in a functional manner, as in turning a lever on a jack-in-the-box.

Symbolic play emerges during the second year (12 to 24 months), and children begin using objects to represent other objects. For example, a toy spoon is used as a comb, or a child can pretend to be drinking something from an empty cup. The length and complexity of pretend (symbolic) play sequences become more pronounced with the child's maturation.

The absence of symbolic play behaviors in a preschool child can be an indicator that the child may be experiencing difficulties in cognitive, language, or social-emotional functioning.

Behavioral Observations

Behavioral observations provide information in several important domains of functioning that are not usually measured by screening tests. Relationship functioning, a child's sense of self, coping, and adaptation skills are not easily measured and are best reported by the parent or observed by the teacher. The following checklist can signal when a child is in need of additional support and attention from teachers.

Observation Checklist:
Assessing Relationship Function

Does the child . . .

- Explore the environment in a normal way?
- Respond to parents/teachers?
- Express emotions?
- React to pain or pleasure?
- Express frustrations?
- Respond to limit setting?
- React positively to physical closeness?
- Respond appropriately to separation from parents?

Tapping into a child's internal structures of thoughts and emotions through playing, storytelling, and drawing pictures are unstructured and informal methods for obtaining a sense of how a child is feeling about the world around him. Does the child's story always end negatively or unresolved? Are pictures of self or others fragmented and distorted all of the time? If the answer is yes, then the child may be experiencing difficulty in the area of social-emotional functioning. The child may be experiencing the world around him as unsupportive and nonresponsive. The child's ability to cope and adapt to the stresses in the environment may be easily taxed and cause behavioral acting out. This child will need additional time and caring within the school environment.

Summary and Recommendations

When the teacher and staff have completed the assessment process, parents should be provided with feedback about the results. Proposed interventions should be explained and discussed with parents. Interventions should address areas of weakness, as well as build upon the child's

domains of strength. A plan should be developed and reviewed several times throughout the year.

Biological and Environmental Risk Factors Affecting Developmental Outcomes for Substance-Exposed Children

There are many myths associated with long-term developmental outcomes for substance-exposed children. In reality, we do not know how cocaine-exposed children will fare because results of the research is still not available. Predictions of negative developmental outcomes for children are being made without supportive evidence. There are some published reports of adverse effects for infants who were prenatally exposed to cocaine, and these observations should raise concern about the possible consequences of this risk factor. However, the literature now available on prenatal cocaine exposure is much too limited to make any predictions about the long-term outcomes for these children.

There are many factors which can contribute to the course and outcome of child development. Substance exposure is but one risk factor. It is the accumulation of risk factors that usually has a deleterious affect on a child's developmental progress. For example, a preterm infant, born early because of the mother's use of cocaine, may have immature respiratory, digestive, and nervous systems, and thus, limited ability to cope with the greater array and intensity of environmental stimuli. The infant may have to remain in the hospital for service before being discharged to foster care. This placement may suddenly terminate after six months, and the child may be placed in temporary care until another foster placement is secured. This child has experienced additional stress just from the changes of caregivers. The quality of care may vary and the child's biological immaturity may be further compromised, creating a high probability for adverse development.

The same child might have been placed with a relative or foster parent and remained in an environment of stable, regular, and nurturing care, showing no difficulties in learning or adjustment in preschool. A child's biological integrity and temperamental differences must be considered in relation to the quality of caregiving to determine the probable risk factors for growth and development.

Developmental screening and assessment should not be used to identify a child as a "drug-baby." The purpose of assessment is to determine the child's developmental status and whether the child is experiencing difficulties in the acquisition of abilities and skills. The assessment will indicate areas of strength and areas of concern. The process will provide an avenue for communication with the parents about the best intervention plan to help a child. The earlier that screening takes place, the more time there is for intervention for children with developmental delays and adjustment problems. The more that assessment is comprehensive, the less possibility there is for misinterpreting a child's behavior. Developmental screening and assessment provide teachers and parents with opportunities for helping children who may be at risk for developmental delays and learning problems.

SUGGESTED INSTRUMENTS

Title: **Early Screening Inventory-3 (ESI-3)**

Authors: S. Meisels, L. Henderson, D. Marsden, and K. Olson (1991)

Purpose: The ESI-3 is a brief preschool developmental screening instrument for three- to four-year-old children. It is designed to identify children in need of more in-depth evaluation. The ESI-3 is an adaptation of the revised ESI for four- to six-year-olds.

For more information about the ESI-3, contact the authors at The Center for Human Growth and Development, University of Michigan, Ann Arbor, MI 48109; (313) 747-1084.

Title: **Denver II**

Authors: William K. Frankenburg, Josiah Dodds, Philip Archer, Beverly Bresnick, Howard Shapiro (1990)

Purpose: The Denver II is designed to be used with healthy children between birth and six years of age. The Denver II screens children in four areas of functioning: personal-social, fine motor-adaptive, language, and gross motor.

For more information on the Denver II, write the publishers at Denver Developmental Materials, Inc., P.O. Box 6919, Denver, CO 80206; (303) 355-4729.

Title: **Early Screening Inventory (ESI)**

Authors: Samuel J. Meisels and Martha S. Wiske (1988)

Purpose: The ESI is intended to survey a child's ability to acquire skills. It is a brief developmental screening instrument that is individually administered to children four to six years of age. The ESI is divided into three main areas: visual-motor/adaptive, language and cognition, and gross motor/ body awareness. A parent questionnaire is part of the screening process. The ESI is available in English and Spanish.

For more information, contact Teachers College Press, 1234 Amsterdam Avenue, New York, NY 10027; (212) 678-3929.

Title: **The Connecticut Infant/Toddler Developmental Assessment (IDA)**

Authors: Sally Provence, Joanna Erikson, Susan EppersonVater, Saro Palmeri (1986)

Purpose: The IDA is an interactive assessment model approach based on a system of procedures which include an integrated evaluation of health, developmental and family-social dimensions. It serves the birth-to-three-years age range. The developmental scales are based on systematic behavioral observations, the use of normed psychological scales, and research. Items represent gross and fine motor development, relationship to inanimate objects, language, and self-help skills. The scales also include domains not represented in other assessments. These new domains are relationship to persons, emotions and feelings, and coping behavior. The summary from the IDA yields classifications of competent, questionable, or of-concern for each of the eight domains.

For more information on the IDA, contact Emily B. Cabezudo, The Riverside Publishing Company, 8420 Bryn Mawr Ave., Chicago, IL 60631; (312) 693-0040.

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GUIDELINES FOR SCREENING AND ASSESSMENT[1]

1. Screening and assessment should be viewed as services — as part of the intervention process and not only as a means of identification and measurement.

2. Processes, procedures, and instruments intended for screening and assessment should only be used for specified purposes.

3. Multiple sources of information should be included in screening and assessment, including the family and community, and ethnic and cultural factors.

4. Developmental screening should take place on a recurrent or periodic basis. It is inappropriate to screen young children only once during their early years. Similarly, provisions should be made for reevaluation or reassessment after services have been initiated.

5. Developmental screening should be viewed as only one path to more in-depth assessment. Failure to qualify for services based on a single source of screening information should not become a barrier to further evaluation for intervention services if other risk factors (e.g., environmental, medical, familial) are present.

6. Screening and assessment procedures should be reliable and valid.

7. Family members should be an integral part of the screening and assessment process. Information provided by family members is critically important for determining whether or not to initiate more in-depth assessment and for designing appropriate intervention strategies. Parents should be accorded complete informed consent at all stages of the screening and assessment process.

8. During screening or assessment of developmental strengths and problems, the more relevant and familiar the tasks and setting are to the child and the child's family, the more likely it is that the results will be valid.

9. All tests, procedures, and processes intended for screening or assessment must be ethnically and culturally sensitive.

10. Extensive and comprehensive training is needed by those who screen and assess very young children.

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[1]Reprinted with permission from Meisels and Provence, pp. 23–26.

APPENDIXES

SUGGESTED RESOURCES

STATE OF CALIFORNIA RESOURCES:

Association of Regional Center Agencies, 910 K St., Suite 300, Sacramento, CA 95814; 916/446-7961. Provide information about regional centers throughout the state, including appropriate referrals for screening. Regional centers provide services for children and adults who are developmentally disabled. Teachers can recommend to families that children be assessed in their area. See pages 60–61 for a list of regional centers in your area.

Beryl Buck Institute for Education, 18 Commercial Blvd., Novato, CA 94949; 415/883-0122. Contact Person: Yolanda Bellisimo. A guide of resources and information for teachers working with children prenatally exposed to drugs.

California Prevention Resource Center, Dept. of Alcohol and Drug Programs, 1700 K St., First Floor, Sacramento, CA 95814; 800/879-2772. Contact Person: Ira Bray. Offers information about alcohol and drug prevention and available resources.

Center for the Vulnerable Child, Children's Hospital Medical Center, 747 52nd St., Oakland, CA 94609; 510/428-3783. Contact Person: Barbara Tittle, M.D. Provides case management to high-risk children and families. The clinic serves chemically dependent parents and their children and provides developmental assessment, parent training, and pediatric care.

Clearing House for Drug-exposed Children, Behavioral and Developmental Pediatrics Dept. at the University of California, San Francisco, Medical Center, 400 Parnassus, Room A203, San Francisco, CA 94143-0314; 415/476-9691. Contact Person: Sean Broderick. The Clearing House has a data base of regional and statewide resources of agencies working with drug-exposed children.

Harbor/UCLA Medical Center - Isan Clinic, 1000 W. Carson St., Torrance, CA 90509; 310/222-1901. Contact Person: M. Lynn Yonekura, M.D. Provides support and care to pregnant women addicted to illicit drugs. Community outreach is offered and developmental testing and assessment is available for children of substance abusing women.

Here They Come: Ready or Not, report of the School Readiness Task Force, California Dept. of Education, Bureau of Publications, Sales Unit, P.O. Box 271, Sacramento, CA 95812-0271. This report reminds us it is not "is the child ready for school" but "is the school ready for the child." The focus is on appropriate educational programs for 4–6-year-olds.

Infant Development Association, c/o Parent Infant Program, DD Council, 160 Franklin St., Suite 205, Oakland, CA 94607; 415/655-9521. Contact Person: Nancy Sweet. *I.D.A. News* is a quarterly publication sent out by the Infant Development Association. This organization keeps abreast of current issues in infant care and development.

Martin Luther King, Jr. Hospital, 12021 S. Wilmington Ave., Los Angeles, CA 90059; 310/668-4657. Contact Person: Xylina Bean, M.D. A county facility that provides a variety of services for substance-exposed children and their families, including medical care for children ages 0–5 who have developmental needs or are at high risk.

Office of Perinatal Substance Abuse, Dept. of Alcohol and Drug Programs, 1700 K St., Fourth Floor, Sacramento, CA 95814; 916/322-6829. Carrie N. Pierce, Perinatal Program Specialist, provides information about resources available for perinatal substance abuse. Ira Bray: 916/324-5439. Provides information and resources on a variety of alcohol and drug topics.

Resources in Special Education (RiSE), California Early Intervention Library, (RiSE/CEI•TAN), 650 Howe Ave., Suite 300, Sacramento, CA 95825; 916/641-5925. Contact Person: Kathy Shea. Offers a variety of materials and resource assistance, data base searches, and linkages to national, state and local projects. Loan materials are available to anyone in California.

NATIONAL RESOURCES:

Crack Babies, also *Crack Babies: Selected Model Practices*, (1990, June). [OEI-03-89-01542 and OEI-03-89-01540]. Dept. of H.H.S., 5600 Fishers Lane, Rockville, MD 20857; 301/443-6245. Publication provides information and resources nationwide that provide guidelines and exemplary programs for prenatally substance-exposed children and families and substance-using mothers.

Drug-exposed Kids: A Crisis in America's Schools [ISBN 0-16-037040-X]. Document on hearings of the U.S. House of Representatives, Select Committee on Narcotics Abuse and Control, Room H2-234, House Office Bldg., Annex #2, Washington, DC 20515-6425.

Elementary School Center (ESC), Two East 103 St., New York, NY 10029; 212/289-5929. Contact Person: Allan Shedlin. Promotes Educating Children from the World of Drugs and Alcohol. Provides materials, videos, and information to parents and educators.

Head Start Bureau Associate Commissioner, P.O. Box 1182, Washington, DC 20013; 202/245-0572. In 1991 the National Association for Perinatal Addiction Research and Education developed a curriculum for training Head Start staff and parents to understand the nature of addiction and how it can affect the child and family. This is an intervention model.

March of Dimes National Office, Birth Defects Foundation, 1275 Mamaroneck Ave., White Plains, NY 10605; 914/997-4722. Free brochures in English and Spanish on use of drugs, alcohol, tobacco use during pregnancy. Also video tapes on "Cocaine's Children" and "Alcohol: Crisis for the Unborn."

National Association for Perinatal Addiction Research and Education (NAPARE), 11 E. Hubbard St., Suite 200, Chicago, IL 60611-3512; 312/329-2512. Publishes research and information updates on perinatal addiction; yearly conference.

National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20852; 301/468-2600; 800/729-6686. Federal clearinghouse for services and information on drugs/alcohol.

National Early Childhood Technical Assistance System (NEC•TAS), CB# 8040, 500 NCNB Plaza, Chapel Hill, NC 27599. Assist states in the implementation of services under P.L. 99-457 for infants, toddlers, and preschoolers with special needs, and their families. It is a collaborative system providing resources and information.

National Organization on Fetal Alcohol Syndrome, 1815 H Street, NW, Suite 750, Washington, DC 20006; 202/785-4586. Contact Person: Patti Munter. Provide information and training on the effects of alcohol on the developing fetus.

National Perinatal Resource Center, Office for Substance Abuse Prevention/Lewin ICF, 1090 Vermont Ave., NW, Suite 700, Washington, DC 20005; 703/218-5500. Technical assistance for those designing and implementing services for children and families; newsletter; national resource data coordination.

National Resource Center for the Prevention of Perinatal Abuse of Alcohol and Other Drugs, 9300 Lee Highway, Fairfax, VA 22031. Contact Person: Teri Condon. 800/354-8824 or 703/218-5600. Established by the Office for Substance Abuse Prevention (OSAP) in conjunction with the Maternal and Child Health Bureau (MCHB). Provide a wide variety of

information and support in prevention of perinatal substance abuse. Community team training institute will train community groups to develop teams working toward prevention.

TRAINING RESOURCES:

Center for Substance Abuse Prevention (CSAP), National Resource Center for the Prevention of Perinatal Abuse of Alcohol and Other Drugs, 9300 Lee Highway, Fairfax, VA 22031; 800/354-8824. Contact Person: Teri Condon. Provide materials, information, training materials, research and activities in the field related to maternal alcohol and other drug abuse.

Covina Development Center, 240 S. Grand Ave., Covina, CA 91723; 818/967-7153. Contact Person: Paula Jeppson. They have worked with children prenatally drug-exposed for a number of years. They provide training and classroom visits can be arranged.

Diagnostic Center for Neurologically Handicapped Children, 1818 W. Ashland Ave., Fresno, CA 93705; Lake Merced Blvd. and Winston Dr., San Francisco, CA 94132. Fresno Center Contact Person: Barbara Kaiser Tilley, 209/445-5982. San Francisco Center Contact Persons: Mary Anne Nielsen, Irene Nystrom-Durkin, Dru Sarin, 415/469-6217. Provide in-service training and technical assistance to school districts. The San Francisco program has completed a video tape to assist teachers when working with at-risk children.

Drug-free Schools and Community Programs, Dept. of Education, University of California, Irvine, Berkeley Place, Suite 245, Irvine, CA 92717-5500; 714/856-7466. Contact Person: Dr. Joan Bissell. Provide training/technical assistance in the area of working with children prenatally substance-exposed.

Early Childhood Development Center, 155 Morey Ave., Sacramento, CA 95838; 916/641-5360. Contact Person: Raymond Walker. Provide training for programs working with at-risk children, including children prenatally substance-exposed. This is an integrated preschool, with special and regular education preschoolers in the same classroom.

East Bay Community Recovery Project, Community Children's Center, 3013 Brookdale Ave., Oakland, CA 94602; 510/261-3961. Contact Person: Sharlin Jones, Child Care Director. Private, nonprofit program providing comprehensive psychological and medical services to drug dependent clients in Oakland and a full-day, child care program for children prenatally substance-exposed.

March of Dimes, 755 Sansome Street, 2nd Floor, San Francisco, CA 94111; 415/788-2202. Contact Person: Ellie Journey. Offers instructional and informational material on prenatal drug exposure. Speakers on prenatal exposure are available for workshops and conferences.

National Institute on Drug Abuse (NIDA), 5600 Fishers Lane, Rockville, MD 20857; 301/443-6245. Referral Line: 800/662-4357. Sponsors research and demonstration grants on drug treatment; collects information on incidence and prevalence; and conducts conferences on maternal drug abuse.

Parent Infant Program (PIP), Children's Hospital, 747 - 52nd St., Oakland, CA 94609; 510/655-9521. Contact: Karen Tanner. Provides an educational and supportive program for families with infants who show delays in their development. There is a center-based component where parents come with their children ages 0–3 to a classroom. Site visits are possible for educators interested in learning more about this program.

Parent-Infant Programs, 1127 Hilltop Dr., Redding, CA 96003; 916/223-3120. Contact Persons: John Chesnut, Ph.D., or Sharon Chesnut. Provide on site support and training to work with at-risk children.

Ravenswood Child Development Center, Parent/Child Intervention Program,

1286 Runnymede St., East Palo Alto, CA 94303; 415/329-2864. Contact Person: Gary Thompson, Director. Birth to 3; have observation room and provide child care for children identified with positive tox screen at birth.

Ronald Reagan Resource Center for Prevention of Birth Defects, Meyer Rehabilitation Institute, University of California/Los Angeles, Department of Pediatrics, 23-10 Rehabilitation Center, 1000 Veteran Ave., Los Angeles, CA 90024-1797; 310/825-4622. Contact Person: Annette Moore. UCLA Dept. of Pediatrics' model programs include Project TEAMS to train workers to deal with the special needs of substance-exposed babies placed with foster parents and relative care providers.

Salvin Special Education Center, Division of Special Education of the Los Angeles Unified School District, 1925 S. Budlong Ave., Los Angeles, CA 90007; 213/731-0703. Contact Persons: Marci Schoenbaum or Mary Jones. This is a pilot research program for substance-exposed children, providing training for teachers about the unique needs of at-risk children. The program targets children who may ultimately be integrated into regular classrooms.

Western Center for Drug Free Schools and Communities, Far West Laboratory, 180 Harbor Dr., Suite 112, Sausalito, CA 94965; 415/565-3000. Contact Person: Carol Burgoa. Training for preschool teachers and caregivers, parents, administrators, special education teachers and K–12 teachers is offered to agencies contracting with Far West Laboratory. The training includes strategies for working with prenatally substance-exposed children and developing school-site planning teams.

WRITTEN RESOURCES:

Children at the front: A different view of the war on alcohol and drugs, (1992). Order: Child Welfare League of America, Inc., 440 First Street, NW, Suite 310, Washington, DC 20001-2085 ($14.95).

Corkery, L. *Guiding our children beyond risk: A handbook for caretakers of prenatally drug-exposed children.* Order: University of California Regents, Drug-Exposed Children, 400 Parnassus Ave., Rm. A203, San Francisco, CA 94143-0314 ($4.00).

Developmentally appropriate practices in early childhood education programs serving children birth through age 8 (ISBN #0-935989-11-0). Order: NAEYC, 1834 Connecticut Ave., NW, Washington, DC 20009-5786 ($5.00).

From Rage to Hope: Strategies for Reclaiming Black & Hispanic Students. Order: National Educational Service, P.O. Box 8, Bloomington, IN 47402; 800/733-6786 or 812/336-7700 ($19.95).

The future of children: Drug-exposed infants, (1991, Spring). Vol. 1, No. 1. Free. Order: Center for the Future of Children, The David & Lucille Packard Foundation, 300 Second Street, Suite 102, Los Altos, CA 94022.

Kids, Crack, and the Community: Reclaiming Drug-Exposed Infants and Children. Order: National Educational Service, P.O. Box 8, Bloomington, IN 47402; 800/733-6786 or 812/336-7700 ($16.95).

Poulsen, M. K. *Perinatal substance abuse: What's best for the children?* (a report by the State of California Child Development Programs Advisory Committee). Order: Child Development Programs Advisory Committee, 915 Capitol Mall, Room 336, Sacramento, CA 95814; 916/653-3977 ($15).

Poulsen, M. K. (1992). *Schools meet the challenge: Educational needs of children at risk due to substance exposure.* Order: RiSE, 650 Howe Avenue, Suite 300, Sacramento, CA 95825 ($10).

Today's challenge: Teaching strategies for working with young children prenatally exposed to drugs/alcohol (1990, March). Order: Los Angeles Unified School District, Salvin Special Education Center, 1925 S. Budlong Ave., Los Angeles, CA 90007; 213/731-0703. Contact Persons: Marci Schoenbaum or Mary Jones.

Villarreal, S. F., McKinney, L. E., & Quackenbush, M. (1992). *Handle with care: Helping children prenatally exposed to drugs and alcohol.* Order: ETR Assoc., P.O. Box 1830, Santa Cruz, CA 95061-1830 ($17.95).

Vincent, L., Poulsen, M., Cole, C., Woodruff, G., & Griffith, D. (1992). *Born substance exposed, educationally vulnerable.*

VIDEOTAPES:

"Drug Baby" (video series designed to facilitate the training of anyone involved in caring for substance-exposed infants). Order: Health Education Services, County of Riverside Dept. of Health, 4065 County Circle Dr., Riverside, CA 92503; 714/358-5385.

"Influences: Innocence betrayed: The long-term effects of prenatal substance exposure." Order: Pyramid Film & Video, 1/800-421-2304; cost: $295 (3-day rental $75).

"Neither damned nor doomed: Teacher's perspective on children exposed to drugs and alcohol" and "Neither damned nor doomed: Mothers' perspective on children exposed to drugs and alcohol." Order: Elementary School Center, Publications Dept., Two East 103rd St., New York, NY 10029; 212/289-5929.

"Safe spaces: Drug and alcohol prevention education for special needs and drug exposed K–2 children" (a staff development film for K–2 special needs educators; Project Healthy Choices). Order: Bank Street College of Education, 610 West 112th St., New York, NY 10025; 212/875-4510.

"What mother takes . . . baby gets," I, II, III (3 parts). Order: Correctional Education/ Hall of Justice, 211 W. Temple St., #808, Los Angeles, CA 90012.

"Women, Drugs and the Unborn Child I & II." Film discusses substance abuse and education, sex education, health and treatment. Also describes pre- and postnatal effects of exposure to alcohol, prescription drugs, pills, marijuana, tobacco, cocaine, heroin, and PCP. Order: Film & Video, 2801 Colorado Ave., Santa Monica, CA 90404; 213/828-7577.

AUDIOTAPES:

"Prenatally Drug-exposed Children," by Rebensdorf, Cardinale, Triebel, Day, & Kilstrom. Conference presentation at the California Assoc. of School Psychologists. Order: Conference Recording Services, 1308 Gilman St., Berkeley, CA 94706; 510/527-3600 (refer to CA592-018).

FREE REFERENCE MATERIALS:

Cocaine babies: Florida's substance exposed youth. Order: Department of Education, Prevention Center, Suite 414, FEC, 325 W. Gains St., Tallahassee, FL 32399.

Drug-exposed infants: A generation at risk, (1990, June). Report of the Chairman, Committee on Finance, U.S. Senate, Washington, DC. Order: U.S. General Accounting Office, Washington, DC 20548 (HRD-90-138).

Roberts, D., & Pinkerton, R. (eds.). (1989, January). *Women, drugs, and babies: Guideline for medical and protective services.* Order: Children's Services Division, Dept. of Human Resources, Child Protective Services Program Manager, 198 Commercial St., SE, Salem, OR 97310-9450.

Special currents: Cocaine babies, (1989). Order: Ross Laboratories, 25 Cleveland Ave., Columbus, OH 43216.

Special currents: Maternal addiction, (1990). Order: Ross Laboratories, 25 Cleveland Ave., Columbus, OH 43216.

NEWSLETTERS:

Assessment Matters (a newsletter of exemplary assessment practices). California Assessment Collaborative, 730 Harrison Street, San Francisco, CA 94107.

Educating At-Risk Youth. National Professional Resources, P.O. Box 1479, Port Chester, NY 10573; 914/937-8879.

FAS Update (Fetal Alcohol Syndrome & other drugs). Prevention Resource Centers, 901 S. 2nd, Springfield, IL 62704; 217/525-3456.

Portfolio Assessment Clearinghouse. San Dieguito Union High School District, 710 Encinitas Blvd., Encinitas, CA 92024; 619/753-6491.

Prevention Forum. Funded by the Illinois Department of Alcoholism & Substance Abuse Prevention Resource Center, 822 S. College St., Springfield, IL 62704; 217/525-3456.

Substance Abuse in Schools. National Professional Resources, P.O. Box 1479, Port Chester, NY 10573; 914/937-8879.

Warmline: iac Networker (interagency alliance for children). Parents & Professionals Working Together, 9175 Kiefer Blvd., Suite 136, Sacramento, CA 95826; 916/383-8339.

ASSOCIATION OF REGIONAL CENTER AGENCIES

910 "K" Street
Sacramento, CA 95814
916/446-7961

REGIONAL CENTERS

Alta California
2031 Howe Avenue, Suite 100
Sacramento, CA 95825
916/924-0400
916/929-1036 (FAX)

Central Valley
5168 North Blythe
Fresno, CA 93722
209/276-4300
209/276-4360 (FAX)

Developmental Disabilities Center, Orange County
530 South Main Street
Orange, CA 92668
714/973-1999, ext. 140
714/547-4365 (FAX)

Eastern Los Angeles
3845 Selig Place
Los Angeles, CA 90031
213/224-4700
213/225-4425 (FAX)

Far Northern
P.O. Box 492418
Redding, CA 96049-2418
916/222-4791
916/222-8908 (FAX)
(1900 Churn Creek Road
Suite 319, Redding, CA 96002)

Golden Gate
120 Howard Street
Third Floor
San Francisco, CA 94105
415/546-9222
415/546-9203 (FAX)

Harbor
P.O. Box 2930
Torrance, CA 90509
310/540-1711
310/540-9538 (FAX)
(21231 Hawthorne Blvd.
Torrance, CA 90503)

Inland
P.O. Box 6127
San Bernardino, CA 92412
714/370-0902 , ext. 502
714/370-3671 (FAX)
(1020 Cooley Drive
Colton, CA 92324)

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3200 North Sillect Avenue
Bakersfield, CA 93308
805/325-8522
805/324-5060 (FAX)

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3440 Wilshire Blvd., Suite 400
Los Angeles, CA 90010
213/383-1300
213/383-6526 (FAX)

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Santa Rosa, CA 95403
707/528-6161, ext. 234
707/542-9727 (FAX)

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8353 Sepulveda Blvd.
Sepulveda, CA 91343
818/891-0920
818/895-5392 (FAX)

Redwood Coast
808 - E Street
Eureka, CA 95501
707/445-0893
707/444-3409 (FAX)

San Andreas
300 Orchard City Drive, Suite 170
Campbell, CA 95008
408/374-9960
408/376-0586 (FAX)

San Gabriel/Pomona
P.O. Box 2280
West Covina, CA 91793
818/814-8811, ext. 302
818/338-2507 (FAX)
(1521 West Cameron, Bldg. A
West Covina, CA 91790)

Tri-Counties
5464 Carpinteria Avenue
Suite B
Carpinteria, CA 93013
805/382-1734
805/684-3034 (FAX)

Westside
5901 Green Valley Circle
Third Floor
Culver City, CA 90230
310/337-1155
310/649-1024 (FAX)

RC of the East Bay
1212 Broadway, Suite 200
Oakland, CA 94612
510/451-7232
510/465-0117 (FAX)

San Diego
4355 Ruffin Road
San Diego, CA 92123
619/576-2996
619/576-2873 (FAX)

South Central Los Angeles
2160 West Adams Blvd.
Los Angeles, CA 90018
213/734-1884
213/730-0793 (FAX)

Valley Mountain
P.O. Box 692290
Stockton, CA 95269-2290
209/473-0951, ext. 217
209/473-0256 (FAX)
(7210 Murray Drive
Stockton, CA 95210)

January 1994

HEALTHY KIDS
HEALTHY CALIFORNIA

For further information on Healthy Kids, contact the center for your region, your county office of education, or the California Department of Education.

HEALTHY KIDS CENTERS

- Region 1
  707/524-2800
  Sonoma County Office of Education
- Region 2
  916/283-6535
  Plumas County Schools
- Region 3
  916/228-2200
  Sacramento County Office of Education
- Region 4
  510/670-4172
  Alameda County Office of Education
- Region 5
  408/479-5204
  Santa Cruz County Office of Education
- Region 6
  209/525-6619
  Stanislaus County Office of Education
- Region 7
  209/730-2692
  Tulare County Office of Education
- Region 8
  805/388-4416
  Ventura County Superintendent of Schools
- Region 9
  619/292-3543
  San Diego County Office of Education
- Region 10
  909/788-6599
  Riverside County Office of Education
- Region 11
  310/922-6601
  Los Angeles County Office of Education
- Healthy Kids Resource Center, Hayward
  510/670-4581

Healthy Kids, Healthy California Office
California Department of Education
721 Capitol Mall
P.O. Box 944272
Sacramento, CA 94244-2720
916/657-2810
FAX — 916/657-5149

TERMS DEFINED

Assessment: Process by which information is gathered about a child to develop a profile of the child's strengths and weaknesses in the domains of cognitive, social-emotional, language, and motor functioning

Caregiver: Preschool teacher or child care provider

Chemical Dependency: Condition in which a person is unable to stop ingesting a chemical, even though it is causing harm to him or her or someone else

Codependent: Person whose life becomes more and more focused on the dependent person. The codependent will take care of the dependent person and the family at the expense of his or her own emotional or physical well-being. Teachers will know that a relationship with a parent or child is codependent when they take care of the parent or child at their own expense.

Developmental Screening: Brief procedure used to identify children in need of more intensive diagnostic assessment

Drug-Exposed: Exposed to illegal drugs

Facilitative Factors: Elements that help the child learn to organize behavior

Fetal Alcohol Effect: Lesser set of the same symptoms as Fetal Alcohol Syndrome

Fetal Alcohol Syndrome: Group of physical and mental birth defects resulting from the mother's consumption of alcohol during pregnancy. These birth defects include small head, low nasal bridge, small eyes, flat midface, short nose, thin upper lip, and indistinct philtrum. Children diagnosed with Fetal Alcohol Syndrome are usually mentally disabled.

Infant: Child from birth to 12 months of age

Integration: Process by which individuals take in information and make it meaningful

Polydrug Use: Use of more than one drug at a given time

Pragmatic Language: Language that is used appropriately and to the best advantage in a particular situation

Prenatal: Occurring before birth

Preschooler: Child from three to five years of age

Primary Caregiver: Parent, foster parent, relative, or other person caring for the child

Protective Factors: Environmental factors that protect a child from being overwhelmed

Sporadic Mastery: Learning behavior that occurs when a child is able to complete a task (mastered the task) on one occasion and unable to complete it on the next occasion

Substance-Exposed: Exposed to harmful drugs, including tobacco, legal drugs, illegal drugs, and alcohol

Sudden Infant Death Syndrome (SIDS): Unexpected death of an apparently healthy infant, usually occurring during sleep

Toddler: Child from 13 to 36 months of age

Visual-Spatial Relationships: Awareness of relationships among objects in relation to self

Publications Available from the Department of Education

This publication is one of over 600 that are available from the California Department of Education. Some of the more recent publications or those most widely used are the following:

Item no.	Title (Date of publication)	Price
1086	California Public Education: A Decade After *A Nation at Risk* (1993)	$4.75
1036	California Strategic Plan for Parental Involvement in Education (1992)	5.75
0488	Caught in the Middle: Educational Reform for Young Adolescents in California Public Schools (1987)	6.75
1072	Commodity Administrative Manual (1993)	13.00
1102	Coordinated Compliance Review Manual, 1993-94 (1993)	8.00
1101	Coordinated Compliance Review Training Guide (1993)	12.00
1034	Course Models for the History–Social Science Framework, Grade Six—World History and Geography: Ancient Civilizations (1993)	9.50
1132	Course Models for the History–Social Science Framework, Grade Seven—World History and Geography: Medieval and Early Modern Times (1994)	12.75
1098	English as a Second Language: Implementing Effective Adult Education Programs (1993)	6.00
1046	English-as-a-Second-Language Model Standards for Adult Education Programs (1992)	7.00
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1065	Physical Education Framework for California Public Schools, Kindergarten Through Grade Twelve (1994)	6.75
0845	Physical Education Model Curriculum Standards, Grades Nine Through Twelve (1991)	5.50
1032	Program Guidelines for Individuals Who Are Severely Orthopedically Impaired (1992)	8.00
1048	Read to Me: Recommended Readings for Children Ages Two Through Seven (1992)	5.50
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